APPENDIX A

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 82-1293

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES, *et al.*

v.

RICHARD S. SCHWEIKER, *et al.*, *Appellants*

Appeal From The United States District Court
for the District of Columbia
(D.C. Civil Action No. 81-03160)

Argued 27 May 1982
Decided 14 September 1982

Margaret E. Clark, Attorney, Department of Justice with whom *Stanley S. Harris*, United States Attorney and *Anthony J. Steinmeyer*, Attorney, Department of Justice were on the brief, for appellants.

James C. Pyles for appellees.

Before: WILKEY, *Circuit Judge*, and ROBB and FAIRCHILD,* *Senior Circuit Judges*.

Opinion for the Court filed by *Circuit Judge* WILKEY.

*Senior Judge, U.S. Court of Appeals for the Seventh Circuit, sitting by designation pursuant to 28 U.S.C. § 294(d) (Supp. IV 1980).

WILKEY, *Circuit Judge:* Appellants, the Secretary of Health and Human Services and the Administrator of the Health Care Financing Administration (hereinafter referred to collectively as the Secretary), appeal from a district court decision invalidating a regulation requiring Home Health Agencies to seek Medicare reimbursement determinations and payments from government-designated regional intermediaries. The Secretary maintains that the district court did not have jurisdiction to decide the issues involved. He also challenges the lower court's holdings that the Secretary lacked the statutory authority to promulgate the regulation and that he failed to comply with the notice and comment requirements of the Administrative Procedure Act (APA).[1]

We hold that the district court properly exercised its jurisdiction and that it correctly concluded that the Secretary was required to comply with the APA's notice and comment provisions. However, we reverse its holding that the Secretary lacked the authority to promulgate the regulation in question.

I. BACKGROUND

A. *Statutory Scheme*

The Medicare Act,[2] enacted in 1965, created two distinct, but interrelated, types of health insurance coverage for the aged and disabled. Part B of the Act covers the cost of physician and non-hospital services.[3] Part A provides coverage for inpatient hospital services, post-hospital extended care services and home health services.[4] Home health agencies (HHAs) provide Part A services to a patient in his home, as a lower cost

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[1] 5 U.S.C. § 553 (1976).

[2] 42 U.S.C. §§ 1395-1395tt (1976 & Supp. IV 1980).

[3] *Id.* §§ 1395j-1395w (1976 & Supp. IV 1980).

[4] *Id.* §§ 1395c-1395i (1976 & Supp. 1980).

alternative to instititutional care.[5] The present litigation involes the mechanism for making reimbursement determinations and payments to HHAs under Part A of the Act.

Under the Act qualified providers of Part A health services are entitled to be reimbursed for the reasonable cost of providing services to Medicare beneficiaries.[6] At the inception of the Medicare program in 1965, HHAs, like other qualified providers, had the option of nominating an intermediary to determine the proper amount of reimbursement and make those payments.[7] When an HHA chose to use an intermediary, the Secretary would enter into a cost-reimbursement contract with the nominated intermediary.[8] Alternatively, if the HHA chose not to use an intermediary, it submitted its claims directly to the Secretary.[9] Under the Act, the Secretary was empowered to perform any of these functions directly or by contract.[10] Payment of claims submitted directly to the Secretary was made by the Office of Direct Reimbursement (ODR) of the Health Care Financing Administration (HCFA).

In 1977 section 1395h, the provision giving providers the right to nominate intermediaries, was amended by the addition of provisions authorizing the Secretary to assign or reassign providers to certain intermediaries if he determined, after applying specified criteria, that the assignment or reassignment would result in the more effective and efficient administration of the Medicare program.[11] In 1980 Congress, respond-

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[5] *Id.* §§ 1395x(m) (1976 & Supp. IV 1980).

[6] *Id.* §§ 1395f(a) & (b), (1395x(m), (o) & (u) (1976 & Supp. IV 1980).

[7] *Id.* § 1395h(a) (Supp. IV 1980).

[8] *Id.*

[9] *Id.* § 1395g (1976 & Supp. IV 1980).

[10] *Id.* § 1395kk(a) (1976).

[11] Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub.L.No. 95-142, 91 Stat. 1175, 1198-99 (1977) (codified at 42 U.S.C. §§ 1395h(e)(1), (2), (3) & 1395h(f) (Supp. IV 1980).

ing to concerns over the "wide variation in administrative and reimbursement practices among intermediaries with respect to home health providers,"[12] further amended section 1395h. The 1980 amendment required the Secretary to designate regional intermediaries for freestanding[13] HHAs electing to use an intermediary.[14] Shortly after the 1980 amendment, the Secretary promulgated the regulation that is the cause of the present controversy.

B. *The Contested Regulation*

On 8 December 1981 the Secretary, without following the notice and comment requirements of the APA, issued an administrative instruction directing freestanding HHAs to begin using forty-nine government-designated, state-wide intermediaries for all Medicare reimbursement determinations and payments.[15] Under the proposed plan, 864 HHAs were reassigned to new intermediaries.[16] Approximately fifty-four per-

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[12] H.R. Rep. No. 1167, 96th Cong., 2d Sess. 368, *reprinted in* 1980 U.S. Code Cong. & Ad. News 5526, 5731-32.

[13] HHAs may either be affiliated with another provider (such as hospital or rehabilitation center), in which case they are referred to as "provider-based", or they may be "freestanding," in which case they operate without such an affiliation.

[14] Omnibus Budget Reconciliation Act of 1980, Pub.L.No. 96-499, § 930(o), 94 Stat. 2599, 2632 (1980) (codified at 42 U.S.C. § 1395h(e)(4) (Supp. IV 1980).

[15] The instruction was included in a letter sent directly to all intermediaries, with directions to furnish copies to the HHAs they served.

[16] The other approximately 2,000 HHAs were to deal with their current intermediaries, since those intermediaries had been designated as regional intermediaries.

cent of these 864 were providers who had previously been dealing directly with the Secretary. At the time the instruction issued the Secretary planned to phase-in the proposed reassignments over a period beginning 1 January 1982 and ending 1 October 1982, with transfers becoming effective at the start of the individual HHA's fiscal year. Subsequently, however, the Secretary accelerated the proposed implementation, by requiring that all transfers be effective by 15 March 1982. Soon after the December 1981 instruction issued, the present litigation ensued.

C. *The Present Litigation*

On 24 December 1981 Appellees, two national associations of HHAs, a corporation which owns and operates forty-eight HHAs, and thirty-seven individual HHAs, filed this action in the district court. Appellees sought to enjoin the Secretary from implementing the reassignment outlined in the December 1981 instruction on the grounds that the instruction violated the Medicare Act, the APA, and the Due Process Clause of the Fifth Amendment. On cross-motions for summary judgment, the district court ruled in Appellees' favor on most of the issues involved.

The court rejected the Secretary's argument that jurisdiction over all but the Appellees' APA claim was precluded by 42 U.S.C. § 405(h), concluding that section 405(h) did not preclude federal question jurisdiction over statutory claims for which no alternative form of judicial review was available.

The court also held in Appellees' favor on the merits, concluding that under the Medicare Act, HHAs which had not previously nominated intermediaries had the right to have Medicare reimbursement determinations and payments made directly by the Secretary. The court further held that the December 1981 instruction did not apply to those HHAs which had elected to deal with an intermediary because it was a rule subject to the notice and comment requirements of the APA, requirements the Secretary failed to follow. Accordingly, the

court enjoined the Secretary from requiring freestanding HHAs to deal with regional intermediaries if they had chosen not to, and ordered that any effort to reassign freestanding HHAs that had elected to use intermediaries be preceeded by the agency's compliance with the notice and comment provisions of the APA.[17] This appeal followed.

II. JURISDICTION

Appellees maintain that the district court had jurisdiction to hear all their claims under 28 U.S.C. § 1331, the general grant of federal question jurisdiction. The Secretary counters by arguing that 42 U.S.C. § 405(h), incorporated by reference into the Medicare Act,[18] precludes the district court from exercising section 1331 jurisdiction. Alternatively, the Secretary for the first time argues that if jurisdiction is not precluded by section 405(h), it has been impliedly precluded by Congress' failure expressly to provide for judicial review of claims like the present ones. Because we agree with the district court's interpretation of section 405(h), we hold that jurisdiction over the present action is not barred by this much-litigated preclusion section.[19] We also hold that Congress did not impliedly

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[17] The district court dismissed Appellees' Due Process claim because it was an attack on the Secretary's future determination of "reasonable costs" and not on the administrative instruction being challenged and because it was based on the "speculative" possibility that Appellees would not be totally compensated for the costs attributable to the transition. *National Association of Home Health Agencies* v. *Schweiker*, No. 81-3160, *slip op.* at 8. (D.D.C. 10 March 1982). The parties have not appealed that ruling.

[18] 42 U.S.C. § 1395ii (1976).

[19] This court has decided two cases involving section 405(h). *Humana of South Carolina, Inc.* v. *Califano*, 590 F.2d 1070 (D.C. Cir. 1978); *Association of American Medical Colleges* v. *Califano*, 569 F.2d 101 (D.C. Cir. 1977). The section has also spawned numerous litigation in other circuits. *United States* v. *Sanet*, 666 F.2d 1370 (11th Cir. 1982); *Hopewell Nursing Home* v. *Schweiker*, 666 F.2d 34

preclude jurisdiction over claims like the present ones by failing expressly to provide for their review.

A. *Jurisdiction Over the Procedural Claims*

Although the Secretary did not object to the exercise of jurisdiction over Appellees' APA claim at the district court level, he has apparently changed his position on appeal, contending that the district court was mistaken in concluding that it had jurisdiction over "*any* of [Appellees'] claims."[20] However, we can easily dispose of the jurisdictional issue with respect to the APA claim by relying on a prior decision of this court.

Section 405(h) of the Social Security Act provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who are parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or an officer or employee thereof shall be brought under sections 1331 or 1346 of title 28 to recover any claim arising under this subchapter.[21]

(4th Cir. 1981); *Daniel Freeman Memorial Hospital* v. *Schweiker*, 656 F.2d 473 (9th Cir. 1981); *Chelsea Community Hospital, SNF* v. *Schweiker*, 630 F.2d 1131 (6th Cir. 1980); *Kechijian* v. *Califano*, 621 F.2d 1 (1st Cir. 1980); *Bussey* v. *Harris*, 611 F.2d 1001 (5th Cir. 1980); *Trinity Memorial Hospital of Cudahy, Inc.* v. *Associated Hospital Service, Inc.*, 570 F.2d 660 (7th Cir. 1977); *South Windsor Convalescent Home, Inc.* v. *Mathews*, 541 F.2d 910 (2d Cir. 1976); *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283 (8th Cir.), *cert. denied sub nom. Faith Hospital Association* v. *Blue Cross Hospital Service, Inc.*, 429 U.S. 977 (1976). As noted later, the courts of appeals have been less than consistent in their interpretation of the scope of section 405(h). *See* text at notes 47-49 *infra*.

[20] Appellants' Brief at 13 (emphasis added).

[21] 42 U.S.C. § 405(h) (1976).

This section was incorporated into the Medicare Act "to the same extent as [it is] applicable."[22] The Secretary contends that section 405(h) precludes the district court from exercising jurisdiction over the APA claim raised by Appellees. However, the law in this circuit is to the contrary.

In *Humana of South Carolina, Inc.* v. *Califano*,[23] this court held that section 405(h) does not bar a claim brought under the APA. The court noted that "in terms [section 405(h)] bars only actions brought to 'recover on any claim' arising under the Medicare Act."[24] Thus, the court concluded, when a suit is brought "simply to vindicate an interest in procedural regularity, Section [405(h)] is not summoned into play."[25] Finding that holding eminently logical, and discovering that at least one other court of appeals has followed it,[26] we see no reason to override it.

The Secretary argues that since *Humana* was decided, Congress has amended the Medicare Act to require that all challenges to reimbursement regulations, whether substantive or procedural, be brought under 42 U.S.C. § 1395*oo* rather than under 28 U.S.C. § 1331, and that accordingly, section 405(h) now precludes federal question jurisdiction over such claims. However, as we explain later,[27] the 1980 amendment referred to did not expand the scope of issues reviewable under section 1395*oo*, it merely provided expedited review for certain issues arising in reimbursement disputes that are otherwise review-

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[22] *Id.* § 1395ii (1976).

[23] 590 F.2d 1070 (D.C. Cir. 1978).

[24] *Id.* at 1080 (footnote omitted).

[25] *Id.* (footnote omitted).

[26] *Daniel Freeman Memorial Hospital* v. *Schweiker*, 656 F.2d 473, 476 (9th Cir. 1981).

[27] *See* text at notes 39-40, *infra*.

able under the statute. Accordingly, we hold that section 405(h) does not preclude claims challenging the Secretary's compliance with the APA.

B. *Jurisdiction Over the Substantive Claim*

Jurisdiction over Appellees' challenge to the Secretary's substantive authority to issue the regulation in question is not as easily decided. The Secretary argues that jurisdiction over this claim is precluded by section 405(h). Alternatively, he maintains that Congress has impliedly precluded all judicial review of such claims by expressly providing for judicial review of some Medicare Act claims without expressly authorizing judicial review of claims such as the present one. However, we find both these arguments unpersuasive and hold that the district court had jurisdiction over Appellees' substantive claim.

1. *Preclusion of Jurisdiction Under Section 405(h)*

The Secretary's first argument is based on the premise that section 405(h) precludes federal question jurisdiction over claims for which the Medicare Act provides alternative routes of review. The Secretary then maintains that Appellees could have brought the present action under the provisions of 42 U.S.C. § 1395*oo* and concludes that jurisdiction under section 1331 is precluded.[28] Although we accept the Secretary's first

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[28] If jurisdiction did exist under section 1395*oo*, requiring Appellees to utilize that section would not merely change the basis under which the district court exercised its jurisdiction. It would require Appellees to refrain from attacking the disputed regulation until they filed a cost report with their intermediaries on or before 31 March 1983. Appellees would then be required to file a claim with the Provider Reimbursement Review Board, which would decide the issue. Following a final decision by the Review Board, or a reversal, affirmance, or modification thereof by the Secretary, Appellees could finally press their claim in federal court. Thus, the Secretary's argument is of more than academic interest.

premise, we are unable to agree with his second. Accordingly, we must reject his conclusion.

a. *The availability of judicial review under section 1395oo.* Section 1395*oo* was enacted in 1972 to provide for review of an intermediary's decision "as to the amount of total program reimbursement due to the provider."[29] Under section 1395*oo* initial review of the intermediary's decision is made by the Provider Reimbursement Review Board (PRRB).[30] A provider dissatisfied with the PRRB's decision then has the right to obtain judicial review of that decision, or of any reversal, affirmance, or modification thereof by the Secretary, by filing a civil action in federal district court.[31] We conclude, however, that this route to judicial review is unavailable to Appellees in the present case.

In *Humana* this court noted that "[c]onsideration by the Provider Reimbursement Review Board . . . is [confined] to disputes over the amount properly reimbursable."[32] Appellees' substantive claim does not involve a dispute over the amount payable under the Act, nor does it involve Appellees' eligibility for reimbursement. Indeed, Appellees seek no money at all. They merely challenge the *method* of reimbursement, a concern that is not cognizable under section 1395*oo*.

The Secretary maintains that Appellees' claims are similar to those which we held were precluded by section 405(h) in *Humana* and in *American Association of Medical Colleges* v.

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[29] 42 U.S.C. § 1395*oo*(a)(1)(A) (1976). Section 1395*oo* review is also available when the intermediary fails to make a final decision in a timely manner, *id.* § 1395*oo*(a)(1)(B) & (C), a situation clearly not involved here.

[30] *Id.* § 1395*oo*(a) (1976).

[31] *Id.* § 1395*oo*(f)(1) (Supp. IV 1980).

[32] *Humana*, 590 F.2d at 1081 (footnote omitted).

Califano (AAMC).[33] However, the claims we found precluded in those cases were fundamentally different from that pressed by Appellees in the present litigation. In *Humana* the plaintiff challenged regulations limiting the amount of reimbursement, a challenge "unmistakenly directed at upsetting on the merits the Secretary's *determination on an element of cost-reimbursement*."[34] We held that such a substantive challenge was precluded by section 405(h) because "Humana's fundamental grievance . . . centers on the *amount of cost-reimbursement* . . . a subject amenable to Review Board adjudication."[35] In *AAMC* a group of Medicare providers challenged a regulation fixing "*limits* on hospital in-patient general routine service *costs*."[36] We held that the district court did not have federal question jurisdiction because section 405(h) precluded jurisdiction over "*suits seeking* eventual realization of *provider-cost reimbursement* under the Medicare Act."[37] Thus, in both *Humana* and *AAMC* the regulations attacked imposed limits on the *amount* of reimbursement. The issues raised in those cases were directly related to a claim for reimbursement. Appellees' claim, on the other hand, does not directly concern the amount of reimbursement they will receive. As noted above, it concerns the mode of reimbursement.

The Secretary further argues that the only reason Appellees are challenging the instruction is that they fear they will incur compliance costs that will not be fully reimbursed, and that therefore, the substantive claim is one seeking *eventual* realization of provider-cost reimbursement. However, regardless of the Appellee's motivation for bringing this suit, reimbursement is not its ultimate goal. Appellees seek to enjoin the

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[33] 569 F.2d 101 (D.C. Cir. 1977).

[34] *Humana*, 590 F.2d at 1079 (emphasis added).

[35] *Id.* (emphasis added).

[36] *AAMC*, 569 F.2d at 104.

[37] *Id.* at 107 (emphasis added).

Secretary from changing the method of processing payment claims. Granting the requested relief will not enable Appellees to receive larger reimbursements. As the district court recognized, Appellees "do not seek any type of eventual monetary recovery on a reimbursement claim by this action."[38]

Finally, the Secretary argues that if claims such as the Appellees' were not previously encompassed by the section 1395*oo* review provisions, they were brought under that section by a 1980 amendment to the Medicare Act. The 1980 amendment allows a provider "to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the [PRRB] determines . . . that it is without authority to decide the question."[39] The Secretary contends that the amendment evidences Congress' intent that claims related in any way to reimbursement disputes be challenged pursuant to section 1395*oo* rather than under section 1331. However, the legislative history behind the amendment reveals that it was not intended to broaden the scope of issues judicially reviewable under section 1395*oo*.[40] The 1980 amendment merely permits expedited judicial review of certain issues arising in reimbursement disputes *otherwise reviewable under the statute*. As explained above, the present claim cannot be characterized as a reimbursement dispute. Therefore, the 1980 amendment does not alter the justiciability of this claim under section 1395*oo*.

Because there is no alternative form of judicial review available to Appellees under the Medicare Act, the Secretary's first

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[38] *Schweiker, slip op.* at 10.

[39] 1980 Omnibus Budget Reconciliation Act, Pub. L. No. 96-499, § 955, 94 Stat. 2599, 2647 (1980).

[40] *See* H.R. Rep. No. 1167, 96th Cong., 2d Sess. 394, *reprinted in* 1980 U.S. Code Cong. & Ad. News 5526, 5757.

argument would appear to fail. However, because that argument is premised on the assumption that section 405(h) precludes only those claims for which the Medicare Act provides an alternative form of judicial review, the Secretary's conclusion would still be correct if section 405(h) barred claims arising under the Medicare Act for which no alternative form of judicial review is available. Thus, we must next determine the scope of section 405(h)'s preclusion.[41]

b. *The scope of section 405(h).* In *Weinberger* v. *Salfi*[42] the Supreme Court held that section 405(h) precluded the exercise of federal question jurisdiction over a constitutional challenge to various provisions of the Social Security Act. However, the Court found that the challenge could be brought under a separate provision of the Social Security Act,[43] thereby implying that the result might have been different had no alternative form of judicial review been available.[44] Since *Salfi* the various courts of appeals have grappled with the issue of whether section 405(h) precludes federal question jurisdiction when no alternative form of judicial review is available.[45] Every court that has considered the issue has agreed that section 405(h) should be read so as to permit *some* avenue of judicial review for *constitutional* claims.[46] However, the result has not been so

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[41] On appeal the Secretary addressed this issue only in a footnote, Appellants' Brief at 24 n.22, despite the district court's observation that its resolution was "far from clear." *Schweiker, slip op.* at 5.

[42] 422 U.S. 749 (1975).

[43] 42 U.S.C. § 405(g) (Supp. IV 1980). This provision, unlike section 405(h), was not incorporated into the Medicare Act. *See* 42 U.S.C. § 1395ii (1976).

[44] *Salfi*, 422 U.S. at 762.

[45] See cases cited in note 19, *supra*.

[46] *Bussey* v. *Harris*, 611 F.2d 1001, 1005 (5th Cir. 1980); *Hospital San Jorge, Inc.* v. *U.S. Secretary of HEW*, 598 F.2d 684, 686 (1st Cir. 1979); *Dr. John T. MacDonald Foundation, Inc.* v. *Califano*, 571 F.2d 328, 331-32 (5th Cir.), *cert. denied*, 439 U.S. 893 (1978); *Trinity*

harmonious when the same courts have considered the effect of section 405(h) on otherwise non-reviewable *statutory* claims.

Three circuit courts have held that section 405(h) precludes all federal courts from exercising jurisdiction over claims arising under the Medicare Act even when no alternative form of judicial review is available.[47] Two courts of appeals have held that section 405(h) precludes the exercise of federal question jurisdiction over claims for which no alternative form of judicial review is available, but only after concluding that the Court of Claims had jurisdiction over such claims.[48] Finally, two circuit courts, the Sixth and the Second, along with the Court of Claims, have held that section 405(h) is not a bar to claims arising under the Medicare Act when there is no alter-

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Memorial Hospital of Cudahy, Inc. v. *Associated Hospital Service, Inc.*, 570 F.2d 660, 667 (7th Cir. 1977); *South Windsor Convalescent Home, Inc.* v. *Mathews*, 541 F.2d 910, 913-14 (2d Cir. 1976); *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283, 291-93 (8th Cir.), *cert. denied sub nom. Faith Hospital Association* v. *Blue Cross Hospital Service, Inc.*, 429 U.S. 977 (1976).

[47] *Kechijian* v. *Califano*, 621 F.2d 1 (1st Cir. 1980); *Hospital San Jorge, Inc.* v. *U.S. Secretary of HEW*, 598 F.2d 684, 686 (1st Cir. 1979); *Trinity Memorial Hospital of Cudahy, Inc.* v. *Associated Hospital Service, Inc.*, 570 F.2d 660, 666 (7th Cir. 1977); *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283, 287-89 (8th Cir. 1976). The Seventh Circuit noted that a federal court might have jurisdiction to review a decision by the Secretary if it were "in direct conflict with an express mandate of the Medicare Act." *Trinity Memorial*, 570 F.2d at 666 n.9.

[48] *Drennan* v. *Harris*, 606 F.2d 846, 850 (9th Cir. 1979); *Dr. John T. MacDonald Foundation, Inc.* v. *Califano*, 571 F.2d 328, 332 (5th Cir.), *cert. denied*, 439 U.S. 893 (1978).

native form of judicial review available.[49] We agree with the district court that the view espoused by the Sixth and Second Circuits and the Court of Claims is the correct one.

We start with the well established principle that an agency bears a "heavy burden of overcoming the strong presumption that Congress did not mean to prohibit all judicial review" of an agency decision.[50] Thus, "only upon a showing of 'clear and convincing evidence' of a contrary legislative intent should the courts restrict access to judicial review."[51] We conclude that the Secretary has failed to meet this heavy burden.

First, the Secretary has cited no legislative history which indicates that Congress intended to preclude jurisdiction over claims which there was no alternative form of judicial review. Indeed, section 405(h) was incorporated into the Medicare Act only to the extent it was applicable.[52] "[T]he entire thrust of the section is to prevent claimants who seek judicial review of their claims for benefits from bypassing the specific procedural requirements provided by Congress in the various acts."[53] Thus, "[t]he subsection does not have a meaningful application in a case where no statutory review mechanism is available."[54]

Second, precluding review of claims like the present one does not further the policy which led Congress to incorporate

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[49] *Chelsea Community Hospital, SNF* v. *Michigan Blue Cross Association*, 630 F.2d 1131, 1134-36 (6th Cir. 1980); *United States* v. *Aquavella*, 615 F.2d 12, 20-21 (2d Cir. 1979); *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 351 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 960 (1977).

[50] *Dunlop* v. *Bachowski*, 421 U.S. 560, 567 (1975).

[51] *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 140 (1967). *See also Rusk* v. *Court*, 369 U.S. 367, 379-80 (1962).

[52] 42 U.S.C. § 1395ii (1976).

[53] *Aquavella*, 615 F.2d at 19.

[54] *Chelsea Community Hospital*, 630 F.2d at 1135.

section 405(h) into the Medicare Act. As the Eighth Circuit noted, Congress adopted section 405(h) because permitting

> [j]udicial review of the amount of all Medicare payments would bring the courts into the complex interplay between physician and hospital in ascertaining the appropriate medical charges for technical services . . . These charges are subject to extensive and complicated statutory guidelines and regulations . . . Determining the proper amount of these charges is a matter peculiarly suited to determination by a specialized agency.[55]

These concerns are not present when actions like the present one are brought to challenge secretarial action unrelated to reimbursement disputes.[56] Finding no clear and convincing evidence to the contrary, we conclude that Congress, by incorporating section 405(h) into the Medicare Act to the extent applicable, did not intend to preclude judicial review of claims for which no alternative form of judicial review was available. Accordingly, we reject the Secretary's argument that section 405(h) precludes jurisdiction in the present case.

2. *Implied Preclusion of Jurisdiction*

In his reply brief the Secretary argues that even if jurisdiction is not precluded by section 405(h), it is nevertheless barred in view of Congress' express delineation of the kinds of

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[55] *St. Louis University*, 537 F.2d at 289.

[56] We do not mean to imply that a federal court may disregard section 405(h) anytime the concerns expressed above are not present. To do so would be to disregard the Supreme Court's statement that "the third sentence of § 405(h) is more than a codified requirement of administrative exhaustion." *Weinberger* v. *Salfi*, 422 U.S. 749, 757 (1975). We note that the articulated concerns are not implicated by allowing courts to decide cases such as the present one only to show that our reading of the statute is reasonable. When section 405(h) does apply, its effect cannot be avoided by resort to exceptions to the administrative exhaustion requirement. *See id.*

claims which may be reviewed under the Medicare Act. Relying on *United States* v. *Erika, Inc.*,[57] the Secretary maintains that since Congress expressly made certain types of cases reviewable under the Medicare Act, issues not reviewable under the Medicare Act, issues not reviewable under section 1395*oo* are not reviewable at all. A review of the Supreme Court's decision in *Erika*, however, indicates that the case does not support the Secretary's point of view.

In *Erika* a physician brought a claim for reimbursement under Part B of the Medicare Act. That part of the Act provides for judicial review of the Agency's determination concerning the physician's *eligibility* for payments, but does not contain a provision permitting review of the Agency's determination of the *amount* of reimbursement. The Supreme Court noted that Congress had provided judicial review for both eligibility and amount determination under Part A of the Medicare Act, but had provided for judicial review of only eligibility determinations under Part B.[58] The Court also examined statements from the legislative history of the Medicare Act and subsequent amendments which clearly indicated an intent to restrict the appealibility of amount determinations under Part B.[59] In the face of these "expressions of legislative intent [which] unambiguously support our reading of the statutory language," the Court concluded that judicial review of amount determinations under Part B of the Act was precluded.[60]

The reasoning utilized by the Supreme Court in *Erika* does not apply to the present claim which was brought under Part A of the Medicare Act. As noted earlier, the general presumption

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[57] 50 U.S.L.W. 4399 (U.S. 20 April 1982).

[58] *Id.* at 4401.

[59] *Id.* at 4401-02 & nn.11-13.

[60] *Id.* at 4402.

is in favor of judicial review.[61] In *Erika* the government overcame this presumption by presenting clear and convincing evidence that Congress intended to preclude judical review. The Secretary argues that the precisely drawn review provisions of Part A,[62] coupled with the omission of an express provision of judicial review for claims like the present one, provides the requisite clear and convincing evidence of Congressional intent to preclude judicial review. However, "[t]he mere fact that some acts are made reviewable should not suffice to support an implication of exclusion as to others. The right to review is too important to be excluded on such slender and indeterminate evidence of legislative intent.' "[63] Where, as here, the statutory language and legislative history is devoid of even the slightest intimation that Congress intended to preclude judicial review over the issues raised by Appellees, the mere fact that other types of issues are expressly reviewable under the Medicare Act does not constitute the clear and convincing evidence needed to overcome the presumption in favor of judicial review. Therefore, we reject the Secretary's second argument, and hold that the district court properly exercised its jurisdiction in the present case.

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[61] *Dunlop* v. *Bachowski*, 421 U.S. 560, 567 (1975); *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 140 (1967); *Rusk* v. *Court*, 369 U.S. 367, 379-80 (1962).

[62] At the inception of the Medicare Act in 1965, part A providers were entitled to judicial review only on issues relating to their eligibility as qualified providers. 42 U.S.C. § 1395ff(c) (1976). *See* S. Rep. No. 404, 89th Cong., 1st Sess. 54-55, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 1995. In 1972 and again in 1974, the Act was amended to permit providers to obtain judicial review of amount determinations as well. *See* 42 U.S.C. § 1395oo(a)-(e) (1976).

[63] *Abbott Laboratories*, 387 U.S. at 141 (quoting L. Jaffe, Judicial Control of Administrative Action 357 (1965).

III. THE SECRETARY'S AUTHORITY TO REQUIRE THAT HHAs DEAL WITH REGIONAL INTERMEDIARIES

The central issue in this case concerns the Secretary's authority to require freestanding HHAs to submit their claims to designated regional intermediaries for processing and payment. The resolution of this issue requires us to determine the relationship among three provisions of the original Medicare Act, sections 1395g, 1395h, and 1395kk.

Section 1395g of the Medicare Act provides:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid at such time or times as the Secretary believes appropriate (but not less than monthly) . . . the amounts so determined . . .[64]

Appellees argue, and the district court held that this section gives HHAs the right to have their reimbursement determinations and payments made directly by the Secretary. Appellees maintain that the Secretary is authorized to delegate this responsibility to an intermediary only if the HHA elects to have payments made through an intermediary under section 1395(a).[65] The Secretary, on the other hand, contends that

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[64] 42 U.S.C. § 1395g(a) (1976).

[65] *Id.* § 1395h(a) (Supp. IV 1980). In pertinent part the statute provides:

> If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization . . . of the amount of the payments required pursuant to this part to be made to such providers . . . and for the making of such payments by such agency or organization to such providers . . .

whatever right is conferred on an HHA by section 1395g is limited by his authority under section 1395kk to "perform any of his functions under this subchapter directly, or by contract providing for payment in advance or by way of reimbursement . . . as the Secretary may deem necessary."[66] Thus, under the Secretary's view, section 1395g merely requires the Secretary periodically to determine the amount due a provider and to pay that amount at least monthly. Section 1395kk then gives him the authority to contract out those reimbursements functions as he deems necessary.

The Secretary's interpretation of the statute appears to be the correct one. Since *McCulloch* v. *Maryland*[67] it has been a general rule of construction that a government entity empowered to perform a function has the authority to use any reasonable tools and means to carry out that function. Thus, that Congress would authorize the secretary to perform *any* of his Medicare functions, including his reimbursement functions, either directly or indirectly is not at all surprising. The need for such flexibility is obvious when one considers the numerous responsibilities assigned to the Secretary under the Medicare Act.

Moreover, the Secretary's contention that section 1395kk empowers him to contract out his reimbursement responsibili-

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[66] *Id.* § 1395kk(a) (1976). In full the statute provides:

> Except as otherwise provided in this subchapter and in the Railroad Retirement Act of 1974, the insurance programs established by this subchapter shall be administered by the Secretary. The Secretary may perform any of his functions under this subchapter directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

[67] 17 U.S. (4 Wheat.) 316 (1819).

ties is bolstered by the Senate Finance Commitee's Report on the Medicare Act, which states:

> Under the [proposed bill], nominated organizations having experience with cost reimbursement could determine the amount of payments and make such payments whether under part A or part B. *In the absence of a suitable nominated organization, the Secretary could contract out all or part of this service or handle the function directly.*[68]

The House also recognized the broad scope of section 1395kk, noting in its report:

> Section [1395kk]provides that, except as otherwise stated, the programs established by title XVIII are to be administered by the Secretary, who may perform *any* of his functions directly or by contract.[69]

Therefore, the clear and reasonable language of the Act, reinforced by appropriate statements from its legislative history, appears to give the Secretary the unequivocal right to designate intermediaries to perform his reimbursement functions and to require that HHAs deal with those intermediaries.

The district court gave three reasons for not adopting this seemingly reasonable interpretation. First, the court found that Congress had repeatedly expressed its understanding that providers had the unqualified option of dealing directly with the Secretary. Second, the structure of subsequent amendments to the original Medicare Act indicated to the

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[68] S. Rep. No. 404, 89th Cong., 1st Sess. 53, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 1994 (emphasis added). Appellees argue that the quoted language refers only to the situation in which a provider elects to use an intermediary, but fails to nominate a suitable one. However, nothing in the report suggests that the language should be read so narrowly.

[69] H.R. Rep. No. 213, 89th Cong., 1st Sess. 174 (1965) (emphasis added).

court that Congress did not believe that the Secretary was empowered to appoint intermediaries for HHAs wishing to deal directly with the Secretary. Finally, the court was persuaded by the Secretary's apparent acquiescence in a 1966 Assistant General Counsel opinion stating that the Secretary did not have the right to designate an intermediary for a provider who did not elect to be served by one. Appellees urge us to adopt the district court's reasoning.[70] However, after examining that reasoning carefully, we remain convinced that there is no need to deviate from the reasonable interpretation advanced by the Secretary.

A. *Congressional Expressions Concerning a Provider's Right to Deal Directly With the Secretary*

The district court was influenced by what it described as "continuing expressions of Congressional understanding that Medicare providers have the option to receive payment from the government directly."[71] However, a close examination of the context in which these expressions were made reveals that Congress was not addressing the issue presently being considered. The statements at most indicate that providers may at times elect to deal with the Secretary. They in no way evidence an intent to abrogate the Secretary's right to conduct his business through an intermediary if *he* so chooses.

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[70] Appellees also argue that the lower court's ruling was correct because as a matter of statutory construction the specific features of section 1395g override the more general provisions of section 1395kk. Rather than quibble over which section is more specific, we merely note that the interpretation we adopt is reasonable and supported by the relevant legislative history. It also gives effect to both provisions in question. In such circumstances, the rule of statutory construction cited by Appellees is not particularly useful.

[71] *Schweiker, slip op.* at 15.

The first statement relied upon by the district court is excerpted from both the Senate and House reports on the original Medicare Act.

> A member of an association whose nominated organization or agency had been selected as a fiscal intermediary could elect to receive payment from another intermediary which had been selected (provided that the other organization or agency agrees) or could elect to deal directly with the Secretary.[72]

It is clear from the context of this statement[73] that the part of the Medicare Act being discussed is section 1395h(d).[74] Section 1395h(d) gives a provider who is a member of an association the right to refuse to use an intermediary chosen by the associa-

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[72] S. Rep. No. 404, 89th Cong., 1st Sess. 52, *reprinted in* 1965 U.S. Code Cong. & Ad News 1943, 1993; H.R. Rep. No. 213, 89th Cong., 1st Sess. 45 (1965).

[73] The statement is in a portion of the report discussing "General provisions relating to the basic and voluntary supplemental plans," so it does not expressly refer to a particular section. Nevertheless, the entire statement refers to providers who belong to an association which has elected an intermediary to which a member of the association objects. The similarity between the quoted language and the statements used to describe the effect of section 1395h(d) further indicate that the quoted language refers to that section. See text at note 75, *infra*.

[74] 42 U.S.C. § 1395h(d) (1976). In full the section provides:

> If the nomination of an agency or organization as provided in this section is made by a group or association of providers of services, it shall not be binding on members of the group or association which notify the Secretary of their election to that effect. Any provider may, upon such notice as may be specified in the agreement under this section with an agency or organization, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination, and any provider which has not made a nomination, may elect to receive payments from any agency or organization which has entered into an agreement with the Secretary under this section if the Secretary and such organization agree to it.

tion. Thus, the quoted language merely indicates that a member of an association cannot be bound by the "*association's* choice of an intermediary. It in no way intimates that the *Secretary* cannot make such a choice.

The next reference relied upon by the district court is likewise an explanation of section 1395h(d). Explicity referring to that section, both Committees noted:

> Section [1395h(d)] provides that if the nomination of an [intermediary] is made by a group or association of providers of services, it will not be binding on members of such group or association which notify the Secretary of their election to that effect. . . . Any provider which has withdrawn its nomination (and any provider which has not made a nomination) may elect to receive payments either directly from the Secretary or from any agency or organization which has entered into an agreement with the Secretary. . . .[75]

Again, the statement merely indicates that the association's choice of an intermediary is not binding on its members. It does not negate the Secretary's authority to designate intermediaries if in his judgment that would be the best way to administer his responsibilities.

The final expressions of Congressional intent which the district court found persuasive were made in 1977 and 1980, when Congress amended section 1395h.[76] These expressions, like the previous ones, do not cast any doubt on the Secretary's right to conduct his business through an intermediary.

In 1977 several provisions were added to section 1395h. The House Committee on Interstate and Foreign Commerce set

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[75] S. Rep. No. 404, 89th Cong., 1st Sess. 164-65, *reprinted in* U.S. Code Cong. & Ad. News 1943, 2104; H.R. Rep. No. 213, 89th Cong., 1st Sess. 147-48 (1965).

[76] The substance and effect of these amendments is discussed later. *See* text at notes 80-85, *infra*.

forth their understanding of the pre-amendment law as follows:

> Under part A of medicare, groups or associations of providers of services, *i.e.*, . . . home health agencies, can nominate an organization to act as a fiscal intermediary between the providers and the Secretary. An individual member of an association or group of providers which has nominated one organization as intermediary may select some other organization as its intermediary if this is satisfactory to the organization and the Secretary, or alternatively, it may elect to deal with the Secretary.[77]

This again appears to be an explanation of section 1395h(d). It therefore does not justify imposing any limits on the language of section 1395kk.

In 1980 when section 1395h was again amended, this time by adding a provision requiring the Secretary to designate regional intermediaries for freestanding HHAs electing to use an intermediary, the Conference Committee Report contained the following language, which Appellees assert clearly evidences Congress' understanding that HHAs had the unlimited right to deal directly with the Secretary. "In requiring the designation of regional intermediaries for home health agencies, it is not the intent of the conferees that home health agencies would be precluded from contracting directly with the Health Care Financing Administration."[78] As discussed in the next section,[79] this language merely indicated that the 1980 amendment did not require the Secretary to designate regional intermediaries for all freestanding HHAs, thereby preserving the Secretary's discretion to permit HHAs to deal directly with him. Nothing in the amendment or the quoted language

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[77] H.R. Rep. No. 393, Part I, 95th Cong., 1st Sess. 68 (1977); H.R. Rep. No. 393, Part II, 95th Cong., 1st Sess. 76 (1977).

[78] H. Rep. No. 1479, 96th Cong., 2d Sess. 129 (1980).

[79] *See* text notes 84-85, *infra*.

indicates that the Secretary's power under setion 1395kk was to be limited by some overriding right of the provider to deal directly with the Secretary.

Thus, nothing in the Congressional expressions relied upon by the district court indicates that section 1395kk is to be read as anything less than an authorization for the Secretary to perform his reimbursement functions through an intermediary. Nor do these expressions contain anything indicating that a provider has an unqualified right under section 1395g to deal directly with the Secretary. Therefore, these expressions do not persuade us to alter our view that section 1395kk authorizes the Secretary to issue the regulation in question.

B. *The Effect and Implication of the 1977 and 1980 Amendments*

Both parties point to the structure and language of the 1977 and 1980 amendments as support for their divergent conclusions. However, we find the two amendments largely irrelevant to the question at hand because they neither increase nor limit the Secretary's power under section 1395kk.

The 1977 amendment authorized the Secretary to "assign or reassign any provider of services" to an intermediary if he determined, after applying certain standards, criteria and procedures, "that such designation would result in more effective and efficient administratioin" of the Medicare program.[80] Contrary to the Secretary's argument that this amendment confirmed or increased his authority to contract out his provider reimbursement functions, we conclude that the amendment merely authorized the Secretary to appoint new intermediaries for providers who had previously elected to use one.

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[80] Medicare-Medicaid and Anti-Fraud and Abuse Amendments of 1977, Pub. L. No. 95-142, 91 Stat. 1175, 1199 (1977) (codified at 42 U.S.C. §§ 1395h(e)(1), (2), (3), & 1395h(f) (Supp. IV 1980)).

The 1977 amendment, entitled "The Medicare-Medicaid Antifraud and Abuse Amendment," was designed to give the Secretary power to deal with the potential problems caused by allowing a provider to chose his own intermediary. The providers' power to nominate or dismiss an intermediary, it was feared, had caused some intermediaries to be overly generous in determining the amounts due a provider under the Act.[81] The amendment therefore required the Secretary to develop precise and uniform standards and criteria for evaluating an intermediary's performance, so that the Secretary would know when an intermediary's performance was unsatisfactory.[82] In such situations the Secretary was authorized to assign the provider to a new intermediary. The inclusion of the term "*assign* or reassign" seems to refer to providers who nominate an intermediary whose performance has already been judged unsuitable, and not to providers who are dealing with the Secretary. This interpretation is consistent with the structure of the amendment since the new provisions were tacked onto sectioin 1395h, the section giving providers the right to nominate an intermediary.[83]

The 1977 amendment did not, therefore, increase the Secretary's authority to require an HHA to deal with an intermediary against his will, a power the Secretary already possessed under section 1395kk. But neither did is limit that power. The amendment simply provided the Secretary with an additional tool for dealing with potential intermediary provider collusion.

Similarly, the 1980 amendment did not affect the Secretary's section 1395kk power one way or the other. That legislation provided: "[T]he Secretary shall designate regional agencies or

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[81] *See* H.R. Rep. No. 393, Part I, 95th Cong., 1st Sess. 68-69 (1977); H.R. Rep. No. 393, Part II, 95th Cong., 1st Sess. 76-77 (1977).

[82] H.R. Rep. No. 393, Part I, 95th Cong., 1st Sess. 69 (1977); H.R. Rep. No. 393, Part II, 95th Cong., 1st Sess. 77 (1977).

[83] 42 U.S.C. § 1395h(a) (Supp. IV 1980).

organizations which have entered into an ageeement with him under this section to perform functions under such agreement with respect to [freestanding] home health agencies . . . in the region."[84] Despite this seemingly mandatory language, it is clear that the amendment did not require the Secretary to assign all freestanding HHAs to regional intermediaries. Rather, the amendment only required the Secretary to designate which intermediary an HHA would use if the HHA elected to use one at all. As noted previously, the House conferees were careful to point out that "[i]n requiring the designation of regional intermediaries for home health agencies, it is not the intent of the conferees that home health agencies would be precluded from contracting dealing with the Health Care Financing Administration."[85] At the same time, however, the amendment did nothing to limit the Secretary's already existing power to require that HHAs deal with an intermediary if he felt it was proper. Thus, neither the 1977 nor the 1980 amendment affected the Secretary's section 1395kk power to perform his reimbursement tasks through intermediaries, a power that the Secretary can use to issue regulations like the present one.

C. *The Effect of the 1966 Assistant General Counsel Opinion*

The district court determined that until the issuance of the December 1981 instruction, the Secretary had consistently interpreted the Medicare Act as legally requiring him to deal directly with providers electing to do so. In reaching this conclusion, the court relied on a 1966 opinion of the Depart-

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[84] Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, § 930(o), 94 Stat. 2599, 2632 (1980) (codified at 42 U.S.C. § 1395h(e)(4) (Supp. 1980)). Provider-based HHAs are to be reassigned only if the Secretary determines, after applying specified criteria, that such assignment will result "in the more effective and efficient administration" of the Medicare program. *Id.*

[85] H. Conf. Rep. No. 1479, 96th Cong., 2d Sess. 129 (1980).

ment of Health, Education and Welfare's (now Health and Human Services) Assistant General Counsel stating that the Secretary did not have the right to designate an intermediary for a provider who did not want to be served by an intermediary[86] and by the Secretary's failure to use this power until almost sixteen years later.[87] While recognizing that the General Counsel's opinion was not binding on the parties, the district court found that, coupled with the Secretary's acquiescence, it was strong evidence that the Secretary's present interpretation of section 1395kk was incorrect.

However, we find that the court erred in placing such great reliance on the actions of the General Counsel and the Secretary. First, when an agency expresses doubts as to its statutory authority to act, such expressions are not binding on a court,

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[86] Memorandum from Melvin Blumenthal, Assistant General Counsel, Health Insurance Division, Department of Health, Education and Welfare (23 Feb. 1966).

[87] Appellees seek to bolster the district court's conclusion by pointing to the Secretary's own regulations which recognize that providers have the option of dealing directly with the Secretary. 42 C.F.R. § 421.103 (1981); 42 C.F.R. § 421.104 (b)(2) (1981). They argue that the December 1981 instruction was invalid because it violated these regulations, which have the force and effect of law.

However, the regulations cited do not address the Secretary's authority under section 1395kk, they merely recognize that normally under section 1395h a provider can elect to deal with an intermediary or with the Secretary. Even if the regulations did conflict with the December 1981 instruction, Appellees argument would still not be persuasive. This court has recognized that an agency's departure from its regulations or past practice is sanctioned as long as it provides a rational explanation for its actions. *Greater Boston Television Corp.* v. *Federal Communications Commission*, 444 F.2d 841, 852 (D.C. Cir. 1970), *cert. denied*, 403 U.S. 923 (1971). If, as we hold, section 1395kk authorizes the Secretary to issue the instruction in question, the Secretary cannot destroy that authority by promulgating regulations.

nor are they due the same deference given to agency determinations requiring special agency competence.[88] As this Court observed in a similar situation, "[when] the question is simply one of statutory interpretation . . . [calling] largely for the exercise of historical analysis and logical and analogical reasoning, it is the everyday staple of judges as well as agencies."[89] Moreover, the 1966 Assistant General Counsel's opinion did nt take into account the legislative history which supports the Secretary's present position.[90] Further, subsequent opinions issued by the same office expressly recognized the Secretary's power to require HHAs to deal with intermediaries.[91] Thus, this isolated opinion questioning the Secretary's statutory authority is not enough to persuade us that we should ignore the otherwise clear language of section 1395kk.

Nor is the Secretary's fifteen-year failure to utilize his section 1395kk power determinative. As the Supreme Court explained in a similar situation:

> The fact that powers long have been unexercised well may call for close scrutiny as to whether they exist; but if granted, they are not lost by being allowed to lie dormant, any more than nonexistent powers can be prescripted by

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[88] *National Petroleum Refiners Association* v. *Federal Trade Commission*, 482 F.2d 672, 694 (D.C. Cir. 1973), *cert. denied*, 415 U.S. 951 (1974).

[89] *Id.*

[90] S. Rep. No. 404, 89th Cong., 1st Sess. 53, *reprinted in*, 1965 U.S. Code Cong. & Ad. News 1994; H.R. Rep. No. 213, 89th Cong., 1st Sess. 174 (1965) (discussed in text accompanying notes 68-69, *supra*).

[91] Memorandum from Juan A. del Real, General Counsel, Department of Health and Human Services 4, 6-7 (11 Jan. 1982); Memorandum from Hank Eigles, Office of General Counsel, Health Care Financing Division, Department of Health and Human Services 5-6 (Dec. 10, 1980).

> an unchallenged exercise. We know that unquestioned powers are sometimes unexercised from lack of funds, motives of expediency, or the competition of more important concerns.[92]

The Secretary's authority to contract out his reimbursement responsibilities did not dwindle away over time as he chose not to use it. Congress conferred that authority upon the Secretary and only Congress could withdraw it. Neither the Office of General Counsel by its opinions, nor the Secretary by his inaction could diminish that authority in the least.

Because we find that Congress in 1965 chose to give the Secretary the power to contract out his reimbursement responsibilities, we hold that the Secretary may now use that power to require freestanding HHAs to seek reimbursement determinations and payments through an intermediary. However, when utilizing that power the Secretary must comply with the procedural requirements imposed by law. It is to those requirements that we now turn our attention.

IV. THE SECRETARY'S COMPLIANCE WITH THE APA

Section 553 of the APA outlines the procedures an agency must follow when promulgating rules. Most notably, the agency is required to provide the public with general notice of its intent to act and to afford all interested parties an opportunity to comment on the proposed action.[93] The Secretary in the

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[92] *United States* v. *Morton Salt Co.*, 338 U.S. 632, 647-48 (1950). *See also Warner-Lambert Co.* v. *Federal Trade Commission*, 562 F.2d 749, 759 (D.C. Cir. 1977), *cert. denied*, 435 U.S. 950 (1978).

[93] In pertinent part, the section provides:

> (b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include—
>
> (1) a statement of the time, place, and nature of public rule making proceedings;

present litigation does not contest the district court's ruling that the December 1981 instruction was a rule within the meaning of the APA.[94] Nor does he dispute the court's finding that he failed to comply with the notice and comment provisions of section 553. However, the Secretary maintains that his actions were proper because the December 1981 instruction was a rule of agency procedure exempt from section 553's

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(2) reference to the legal authority under which the rule is proposed; and

(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this subsection does not apply—

(A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or

(B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.

(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

5 U.S.C. § 553(b) & (c) (1976).

[94] The APA defines a rule as

the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency and includes the approval or prescription for the future of rates,

notice and comment requirements.[95] Thus, the procedural validity of the Secretary's actions depends on whether the December 1981 instruction can be brought within this "limited" exception.[96] We hold that it cannot.

Exceptions to the notice and comment provisions of section 553 are to be recognized "only reluctantly."[97] Otherwise, the salutory purposes behind the provisioins would be defeated. The notice and comment requirements were included in the APA for two main reasons. First, "to reintroduce public participation and fairness to affected parties after governmental authority has been delegated to unrepresentative agencies."[98] And second, to "assure[] that the agency will have before it the facts and information relevant to a particular administrative problem, as well as suggestions for alternative solutions."[99] This dual purpose of fairness and agency self-education is advanced if "[e]xceptions [are] recognized only where the need

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wages, corporate or financial structures or reorganization thereof, prices, facilities, appliances, services or allowances therefor or of valuations, costs, or accounting, or practices bearing on any of the foregoing.

5 U.S.C. § 551(4) (1976).

[95] Section 553(b) (A) provides: "Except when a notice or hearing is required by statute, this subsection does not apply—to interpretative rules, general statements of policy *or rules of agency organization, procedure, or practice* . . ." 5 U.S.C. § 553(b)(A) (1970) (emphasis added).

[96] *Batterton* v. *Marshall*, 648 F.2d 694, 701 (D.C. Cir. 1980).

[97] *Humana*, 590 F.2d at 1082.

[98] *Batterton*, 648 F.2d at 703 (footnote omitted). *See also Pickus* v. *United States Board of Parole*, 507 F.2d 1107, 1112 (D.C. Cir. 1974).

[99] *Guardian Federal Savings & Loan Association* v. *Federal Savings & Loan Insurance Corp.*, 589 F.2d 658, 662 (D.C. Cir. 1978). *See also Brown Express, Inc.* v. *United States*, 607 F.2d 695, 701 (5th Cir. 1979); *Pickus* v. *United States Board of Parole*, 507 F.2d 1107, 1112 (D.C. Cir. 1974); *Texaco, Inc.* v. *Federal Power Commission*, 412 F.2d 740, 744 (3d Cir. 1969).

for public participation is overcome by good cause to suspend it, or where the need is too small to warrant it."[100] Therefore, the "exception of section 553(b)(A) . . . does not extend to those procedural rules that depart from existing practice and have a substantial impact on those regulated."[101] Or, to use the words of this court, "[t]he exemption [for rules of agency procedure] cannot apply . . . where the agency action trenches on substantive rights and interests."[102]

The December 1981 instruction does substantially affect the rights and interests of freestanding HHAs. Although we have held that these HHAs do not have an unlimited statutory right to deal directly with the Secretary, it is undisputed that for sixteen years freestanding HHAs had the option of choosing to deal with the Secretary or with an intermediary. Thus, freestanding HHAs had at least a qualified right to choose with whom they dealt. The December 1981 instruction foreclosed that option, eliminating the qualified right. Furthermore, the elimination of this right will cause freestanding HHAs great expense and inconvenience. Appellees presented uncontradicted evidence that the transfer will cost an estimated $10 million to $30 million. Many HHAs will be required to change or scrap electronic billing systems which have been designed to interface with equipment used by the Secretary. Numerous HHAs will be required to train and re-educate employees to implement the new system and operate within the guidelines of the new intermediary. This potential inconvenience was exacerbated by the Secretary's decision to speed up implementation of the transfer to 10 March 1982. The disruption caused by the transfer may not be great enough to persuade the Secretary to rescind the instruction, but the potential impact is such that the fairness element of section 553 requires that the

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[100] *Batterton*, 648 F.2d at 704 (footnote omitted).

[101] *Brown Express, Inc.* v. *United States*, 607 F.2d 695, 702 (5th Cir. 1979).

[102] *Batterton*, 648 F.2d at 708 (footnote omitted).

HHAs involved be given a chance to present their case to the Secretary before he acts.

In addition, other decisions made by the Secretary in the December 1981 instruction were such that he could have benefited from the HHA's viewpoint. The December 1981 instruction not only foreclosed freestanding HHAs from dealing directly with the Secretary, it also delineated the regioins to be served by each intermediary and designated which intermediary would be chosen as the intermediary for each region. It is hard to image that HHAs, which had been dealing with the various intermediaries and working with the various intermediaries and working with Medicare system for years, would not be able to provide the Secretary with valuable information concerning the most efficacious manner in which the regions could be organized and insights about the various organizations which might be chosen as regional intermediaries.

Thus, compliance with the notice and comment requirements of section 553 would not only result in increased fairness to freestanding HHAs, it would also enable the Secretary to receive valuable information concerning the various issues involved before he chose his course of direction. In such circumstances, the procedural exception to section 553 cannot apply.[103] As this court has previously observed:

> Congress was alert to the possibility that these exceptions might, if broadly defined and indiscriminately used, defeat the section's purpose. Thus, the legislative history of

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[103] The Secretary argues that our decision is controlled by our prior decision in *Guardian Federal Savings & Loan Association* v. *Federal Savings & Loan Insurance Corp.*, 589 F.2d 658 (D.C. Cir. 1978). In *Guardian* this court held that a rule requiring that the audit of federal savings and loan institutions be performed by private auditors rather than by FSLIC was exempt from the notice and comment provisions of section 553. However, that case is distinguishable. First, unlike HHAs, the Savings and Loans involved in *Guardian* never had the freedom to choose who audited them. Thus, no right was eliminated by the Secretary's action. Second, as pointed out above, the December 1981 instruction did more than foreclose

> the section is scattered with warnings that various of the exceptions are not to be used to escape the requirements of section 553. [Citations omitted]. Further, the Senate Committee responsible for considering the APA concluded its report by investing courts with a "duty . . . to prevent avoidance of the requirements of the bill by any manner or form of indirection . . . ."[104]

We would not be true to that duty if we allowed the Secretary to ignore the requirements of section 553 when promulgating rules which, like the present one, substantially affect private parties and resolve important issues without the beneficial input that those parties could provide.

V. CONCLUSION

Wishing to provide the Secretary with the tools he needs to perform his Medicare responsibilities, Congress empowered him to perform those functions either directly or by contract. The Secretary is free to use that power to require HHAs to deal with intermediaries whenever he deems necessary. However, when he chooses to utilize his authority in that manner he must comply with the procedural requirements imposed by the APA.[105]

HHAs from dealing directly with the Secretary, it created regions and designated regional intermediaries, actions that further affected HHAs, and which involved issues on which HHA input would have been valuable. The rule in *Guardian* merely stated that the Secretary would not perform the required audit, it did not designate who would perform it. Finally, the potential impact on the Savings and Loan was not clearly outlined in *Guardian*, where as here Appellees have presented uncontradicted evidence of the potential disruption caused by the December 1981 instruction.

[104] *American Bus Association* v. *United States*, 627 F.2d 525, 528 (D.C. Cir. 1980).

[105] The district court ordered the Secretary to comply with the notice and comment provisions of section 553 before attempting to *reassign freestanding HHAs who had elected to use an intermediary*. That order should be expanded to require compliance with section 553 before a rule assigning *any* freestanding HHA to an intermediary.

The district court correctly held that it had jurisdiction to decide this case and that the Secretary's actions are subject to the notice and comment requirements of the APA. We affirm those holdings.[105] However, the court erred in the disposition of Appellees' substantive claim and, to that extent, we must reverse.

It is so ordered.

APPENDIX B

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 82-1293

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES, *et al.*

v.

RICHARD S. SCHWEIKER, *et al.*, *Appellants*

September Term, 1982
CA 81-03160

United States Court of Appeals
for the District of Columbia Circuit

FILED October 27, 1982

GEORGE A. FISHER
CLERK

Before: Wilkey, Circuit Judge; Robb, Senior Circuit Judge and Thomas E. Fairchild,* Senior Circuit Judge for the Seventh Circuit.

ORDER

Upon consideration of appellees' motion for stay of mandate pending application for certiorari, of appellants' opposition and of appellees' reply to appellants' opposition, it is

ORDERED, by the Court, that appellees' aforesaid motion for stay of mandate is granted and the Clerk is directed not to

issue the mandate herein for a period of thirty (30) days f m the date of this order.

Per Curiam

For the Court:

George A. Fisher
GEORGE A. FISHER
Clerk

RECEIVED
October 28, 1982
WEISSBURG & ARONSON INC.

*Sitting by designation pursuant to Title 28 U.S.C. § 294(d).

APPENDIX C

United States District Court

FOR THE DISTRICT OF COLUMBIA

Civil Action No. 81-3160

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES, *et al. Plaintiffs,*

v.

RICHARD S. SCHWEIKER, *et al., Defendants.*

FILED
March 10, 1982
JAMES F. DAVEY, Clerk

MEMORANDUM OPINION

Plaintiffs in this action are two national associations of home health agencies (HHAs) who bring the cause on behalf of their member agencies which participate in the Medicare program, a corporation which owns and operates 48 home health agencies, and 37 individual home health agencies which participate in the Medicare program. HHAs provide nursing and other therapeutic services as well as certain medical supplies to homebound individuals, most of whom are covered by the Medicare program by virtue of the fact that they are aged or disabled. The Medicare Act entitles plaintiffs to be reimbursed for the "reasonable cost" of covered home health services provided to Medicare beneficiaries. 42 U.S.C. § 1395f, *et seq.*

On December 8, 1981, defendants issued an administrative instruction (Pltfs.' Ex. 2) which compels plaintiffs to seek Medicare reasonable cost determinations and reimbursement from government-designated regional intermediaries. Private organizations, often health insurance companies such as Blue

Cross, serve as intermediaries. Previously, plaintiffs had the option, which most of them selected, to have determinations made by and receive payment directly from the federal government through its Office of Direct Reimbursement (ODR). They seek to enjoin implementation of the instruction on the grounds that it abrogates their statutory and regulatory rights to receive payment directly from the government; that the intermediaries were designated without application of the proper statutory and regulatory standards, criteria and procedures to assure the effective and efficient administration of Medicare payments; and that the new policy is a substantive rule which was not promulgated in accordance with the rulemaking requirements of the Administrative Procedures Act (APA). Plaintiffs also seek an order requiring defendants to make ODR available to health care providers who do not wish to receive Medicare reimbursement determinations and payment through an intermediary, and to enjoin the instruction as it applies to HHAs who previously received reimbursement through intermediaries of their choice and are now required to transfer to the designated regional intermediaries. Although plaintiffs admit that defendants have the statutory authority to designate the intermediaries for those HHAs who choose to be served by an intermediary rather than ODR, they contend that the designation of intermediaries here did not comply with statutory and regulatory requirements, and should have been promulgated in accordance with APA rulemaking procedures.

Plaintiffs originally sought a preliminary injunction, claiming irreparable harm because of increased costs. Costs alleged are based on the necessity to abandon billing systems in which considerable investment has been made and develop different systems to meet the specifications of the new designated intermediaries; retrain and re-educate employees to implement and operate the new billing systems and function within the guidelines of the regional intermediary; change the types of forms used by intermediaries for bill processing; and for agencies that serve patients in more than one state, the necessity to implement different systems for the regional intermediaries in

each state. Although defendants have represented that providers like the plaintiffs can seek adjustments in their reimbursements to compensate for any reasonable costs incurred due to the transition, they were unable to reach a stipulation that could allay plaintiffs' fear that all of their actual costs will not be reimbursed. Plaintiffs contend that the government's plan to reimburse costs of the transition only proportionally to the percentage of Medicare patients in the facility's clientele unfairly fails to compensate expenses which are 100% attributable to the Medicare program. They further assert that since HHAs typically operate with few assets or cash reserves, non-reimbursed costs or an interruption in cash flow during the transition could threaten their very existence. Interruptions in cash flow are likely to occur, they allege, and in fact are occurring to some of the agencies which made the transition as of January 1 of this year, because the new intermediaries are not now equipped to take over the services of ODR or other intermediaries and perform efficiently and effectively.

The parties reached an agreement whereby plaintiffs would abandon their request for a preliminary injunction, incorporating the arguments from that motion into a motion for summary judgment, recognizing that to accommodate the exigencies the case would be decided on cross motions for summary judgment no later than March 10, 1982.

Although the transition to the new regional intermediaries was originally scheduled to be phased in over a year, effective for each HHA at the commencement of its cost reporting year, the transition was subsequently accelerated such that all HHAs would be transferred by March 15. When plaintiffs now dealing with ODR were instructed to begin submitting their bills to the new intermediaries on March 1, they sought a temporary restraining order. On March 1, 1982 defendants were enjoined from requiring plaintiffs to submit their bills other than to ODR for a period of 10 days.

Prior to any decision on the merits, jurisdiction over the subject matter must be determined. Although it is undisputed

that jurisdiction lies regarding the claim under the APA, jurisdiction over the remaining matters is challenged by defendants.

Defendants claim that jurisdiction over all but the APA claims is precluded by section 205(h) of the Social Security Act, 42 U.S.C. § 405(h), incorporated into the Medicare Act by section 1872, 42 U.S.C. § 1395ii.[1] Section 405(h) provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decisions of the Secretary shall be reviewed by any person, tribunal or government agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under § 1331 and 1346 of title 28 to recover on any claim arising under this subchapter.

In *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), a class action challenging the constitutionality of sections of the Social Security Act prohibiting a wage earner's widow or stepchild from receiving insurance benefits unless their relationships to the wage earner existed at least nine months prior to his death, the Supreme Court interpreted § 405(h) to bar federal question jurisdiction (under 28 U.S.C. § 1331). It rejected the district court's conclusion that § 405(h) amounted to no more than a codification of the doctrine of exhaustion of administrative remedies, and that exhaustion could be excused upon a judicial finding of futility. The third sentence of § 405(h), the Court stated, "is sweeping and direct and . . . states that *no* action shall be brought under § 1331, not merely that only those actions shall be brought in which administrative remedies have been exhausted." *Salfi*, at 757. The Court went on to decide that the claim arose under Title II of the Social Security Act

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[1] The Medicare Act was enacted as amendment to the Social Security Act. It is Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* § 405(h) was originally applicable to Title II of the Social Security Act, which contains old-age, survivors, and disability insurance programs codified at 42 U.S.C. § 401 *et seq.*

(thereby barring federal question jurisdiction) and not under the Constitution, since it was Social Security benefits that plaintiffs sought to recover, and the Social Security Act provided both the standing and the substantive basis for the presentation of the constitutional contentions. However, jurisdiction under 42 U.S.C. § 405(g) of the Social Security Act, providing for district court review of the final decision of the Secretary after a hearing, was found over the claims of the named appellees, but not of the unnamed members of the class, for whom a final decision of the Secretary after a hearing was not alleged. Essentially the Court held that § 405(h) did not permit an alternative to § 405(g) jurisdiction, even where the administrative process mandated there could not resolve the constitutional question in issue.

The *Salfi* Court distinguished *Johnson* v. *Robison*, 415 U.S. 361 (1974), which found federal question jurisdiction over a constitutional attack on a statutory provision of the Veterans' Readjustment Benefits Act of 1966 despite a similar preclusion of review provision. In *Robinson*, there was no alternative avenue for review. Statutory preclusion of all review of a constitutional question would be "not only . . . extraordinary, such that 'clear and convincing' evidence would be required before we would ascribe such intent to Congress, but it would . . . [raise] a serious constitutional question of the validity of the statute so construed." *Salfi*, at 762. (Citations omitted). The scheme in the Social Security Act, on the other hand, was found not only constitutional but "manifestly reasonable," in that it "assures the Secretary the opportunity prior to constitutional litigation to ascertain, for example, that the particular claims involved are neither invalid for other reasons nor allowable under other provisions of the Social Security Act." *Id.*

Contrary to defendant's argument, the application of § 405(h) and *Salfi* to claims under the Medicare Act for which there is no alternative route to judicial review, as is the case here, is far from clear. As we have seen, the *Salfi* Court strongly suggested that it might have reached a different

result had there been no alternative basis for jurisdiction. The Courts of Appeals have come to varying conclusions when confronted with the issue. The First, Second, Fifth, Seventh and Eleventh Circuits have found that § 405(h) precludes judicial review over all Medicare cost reimbursement disputes, except as provided in the statute, save when they present constitutional claims. *Kechijian* v. *Califano*, 621 F.2d 1 (1st Cir. 1980); *Hospital San Jorge, Inc.* v. *United States Secretary of Health, Education and Welfare*, 598 F.2d 684 (1st Cir. 1979); *South Windsor Convalescent Home, Inc.* v. *Mathews*, 541 F.2d 910 (2d Cir. 1976); *Bussey* v. *Harris*, 611 F.2d 1001 (5th Cir. 1980); *Alabama Hospital Association* v. *Califano*, 587 F.2d 762 (5th Cir.), *cert. denied*, 444 U.S. 826 (1979); *Dr. John T. MacDonald Foundation, Inc.* v. *Mathews*, 554 F.2d 714 (5th Cir. 1977), *vacated, Dr. John T. MacDonald Foundation* v. *Califano*, 571 F.2d 328 (1978) *(en banc), cert. denied*, 439 U.S. 893 (1978); *Trinty Memorial Hospital of Cudahy, Inc.* v. *Associated Hospital Service, Inc.*, 570 F.2d 660 (7th Cir. 1977); *United States* v. *Sanet*, No. 81-5192 (11th Cir. decided February 1, 1982). Of these, the First Circuit has stated that jurisdiction under § 1331 might be available in the case of a colorable constitutional claim, *Kechijian; Hospital San Jorge*, and the Second Circuit, while generally referring such Medicare claims to the Court of Claims, e.g. *South Windsor*, in at least one case has assumed jurisdiction under § 1331, in part because no alternative remedy, including the Court of Claims, was available. *United States* v. *Aquevella*, 615 F.2d 12 (2d Cir. 1979).

The Fifth, Seventh, and Eleventh Circuits have not reached the question of whether § 1331 jurisdiction would ever be available in a Medicare case, because in the cases presented, jurisdiction was found in the Court of Claims. E.g. *Bussey; Trinity Memorial Hospital of Cudahy; Sanet.* (The instant case, in which declaratory and injunctive relief, rather than money damages, is sought, could not be brought in the Court of Claims, 28 U.S.C. § 1491, and neither could it be reframed as a claim for money damages. *See American Association of Coun-*

cils of Medical Staffs of Private Hospitals v. *Califano*, 575 F.2d 1367 (5th Cir. 1978)). The Ninth Circuit has held that § 1331 jurisdiction is generally unavailable, even over non-procedural constitutional claims, but also found jurisdiction in the Court of Claims, *Drennan* v. *Harris*, 606 F.2d 846 (9th Cir. 1979), and the Court of Claims has affirmed its own jurisdiction. *Whitecliff, Inc.* v. *United States*, 536 F.2d 347 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977).

The District of Columbia, Eighth, and Ninth Circuits have held that purely procedural claims are not barred from federal question jurisdiction by § 405(h), because they are not actions "to recover on any claim" arising under the Medicare Act. *Humana of South Carolina, Inc.* v. *Califano*, 590 F.2d 1070 (D.C. Cir. 1978); *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283 (8th Cir. 1976), *cert. denied sub nom. Faith Hospital Association* v. *Blue Cross Hospital Service, Inc.*, 429 U.S. 977 (1976) (It appears from the language of this case that § 1331 jurisdiction might be found for all constitutional questions); *Daniel Freeman Memorial Hospital* v. *Schweiker*, 656 F.2d 473 (9th Cir. 1981).

The Sixth Circuit and the Court of Claims have found federal court jurisdiction more broadly available. In *Chelsea Community Hospital, SNF* v. *Michigan Blue Cross Association*, 630 F.2d 1131 (6th Cir. 1980), the Sixth Circuit ruled that § 1331 jurisdiction lies where no specific statutory avenue to judicial review is open. The Court of Claims has held that review is available where no administrative channels leading to review have been provided, at least so far as to ensure compliance with statutory and constitutional provisions. *Whitecliff*.

The Fourth Circuit has so far left open the question of jurisdiction over claims for which no alternative method of review is available, *Hopewell Nursing Home* v. *Bechtman*, No. 80-1846 (4th Cir., decided November 30, 1981), and our own Circuit, while implying agreement with courts holding that some avenue of review must be available where no administrative procedure is provided, *Humana* at 1076-77, has not

directly decided the issue. In *Humana*, some of the related claims were subject to administrative review, and the Court held that those procedures should be exhausted before court review of any of the claims. The district court there was ordered to retain jurisdiction over the claims not subject to administrative review, and decide, if necessary, its authority over those claims after administrative exhaustion concerning the other claims. *Id.* at 1085.

To draw at least one strand of agreement from this confusion, every court which has considered the issue, including the Supreme Court and our own Circuit Court of Appeals has stated, at least in *dicta*, that *some* avenue of judicial review must be available for constitutional claims. There is no hesitation in deciding that in this case, where review is not provided for in the Medicare Act and is not available in the Court of Claims, jurisdiction would lie in this court over constitutional claims. The more difficult question, and the one on which we must focus, is whether the plaintiffs' non-APA claims are in fact constitutional claims, and if not, should § 405(h) be interpreted in a manner which precludes review of statutory claims altogether.

Plaintiffs do not allege that they have a property interest in continuing to receive payments directly from the federal government. Rather, they assert a property interest in the unreimbursed expenses expected to be incurred due to the forced transition to designated intermediaries. (Plaintiffs' Opposition to Defendants' Motion for Summary Judgment and Plaintiffs' Motion for Summary Judgment at 51.) Accordingly, plaintiffs' claim of deprivation of property without just compensation in violation of the Fifth Amendment rests not on their claim of statutory entitlement to direct reimbursement or of statutory and procedural violations in the selection of intermediaries, but on a possible future uncompensated loss due to defendants' expected failure to reimburse what plaintiffs consider to be 100% of the costs attributable to the transition. If alleged, this claim, clearly speculative at this juncture, would be an attack on the Secretary's determination of "reasonable

costs" related to the transition, and not on the administrative instruction which is the subject of this case. Plaintiffs' asserted constitutional claim is in fact not part of this case. Their claimed rights to direct reimbursement, and to application of certain procedures in selecting intermediaries, do not have a constitutional basis. We are required to decide then whether § 405(h) bars nonconstitutional statutory claims in this case.

Although some courts have clearly held that only constitutional claims escape the jurisdictional bar of § 405(h), see pp. 5-6, *supra*, neither the Supreme Court nor the D.C. Circuit has reached this issue, and the Sixth Circuit and the Court of Claims have determined that federal jurisdiction is available over otherwise non-reviewable statutory claims. *Id.* Without binding precedent to guide us, we examine now both the rationale behind decisions holding that there is, or is not, jurisdiction, and any indications our own Circuit Court has given as to which way it would rule if faced with this issue.

Courts which have held review of Medicare claims to be precluded have relied primarily upon the Supreme Court's language in *Salfi* to the effect that § 405(h) is more than a codification of the doctrine of exhaustion of administrative remedies, and precludes all actions under § 1331, even claims embracing constitutional issues which cannot be reached in the administrative process. However, the context in which that language appeared in *Salfi* was in refutation of the district court's conclusion that exhaustion was not required because it appeared futile. The practical result in *Salfi* was to require administrative exhaustion, not to foreclose relief altogether. The doubts which the Supreme Court expressed as to the constitutionality of § 405(h) if interpreted to preclude all judicial review of constitutional questions have been echoed, as we have seen, by all the Circuit Courts which have encountered the issue under the Medicare Act, which unlike Title II of the Social Security Act, does not have an all-encompassing provision for administrative procedures leading to judicial review. Interpretations which avoid constitutional doubts have varied. Section 405(h) has been interpreted to preclude all review

under § 1331, but because by its terms it is not applicable to review in the Court of Claims, a forum for judicial review has been provided. Or, the phrase applying § 405(h) to the Medicare Act "as applicable" has been interpreted to mean that it does not apply to constitutional claims for which there is no other avenue of relief. Or, the particular cause of action is not seen as an action to "recover on any claim arising under the Act" because it does not seek to reverse the Secretary's decision concerning an actual claim for payment, but rather to attack the procedures employed in reaching a determination.

The same reasoning can apply to statutory claims. Although the language of *Salfi* referred to constitutional claims, the issue in that case being clearly of a constitutional nature, "the problem presented by a preclusion of review of a regulation for compliance with the authorizing statute is obviously quite similar." *Humana of South Carolina, Inc.* v. *Mathews*, 419 F. Supp. 253, 258 n.2 (D.D.C. 1976), *rev'd in part on other grounds sub nom. Humana of South Carolina, Inc.* v. *Califano*, 590 F.2d 1070 (1979). While the Circuit Court in *Humana* reversed in part the district court, holding that it should not have decided certain matters where related matters were subject to administrative review, it did not contradict the district court's statement that "[i]f . . . the Medicare Act does not provide . . . a mechanism [for review], nonstatutory judicial review continues to be available," *Humana*, 419 F. Supp. at 258, but rather left that question for later determination if necessary. *Humana*, 590 F.2d at 1085. In view of the general presumption in favor of judicial review of administrative action, *see e.g. Abbott Laboratories* v. *Gardner*, 387 U.S. 145 (1967), and the reasoning in the *Humana* cases, we conclude that § 405(h) should not be interpreted to preclude our jurisdiction over statutory claims under the Medicare Act where no alternative route to review is available. In addition to the total preclusion of review which could result, this case is also distinguished from *Salfi* and other cases which declined jurisdiction in not being a case "to recover on any claim" arising under the Medicare Act. Plaintiffs do not seek any type of eventual

monetary recovery on a reimbursement claim by this action. This case does not fit the language of § 405(h), nor the rationale of some courts which have denied review of provider reimbursement claims not previously subject to administrative review because they would "bring the courts into the complex interplay between physician and hospital in ascertaining the appropriate medical charges for technical services . . . . a matter peculiarly suited to determination by a specialized agency." *St. Louis University* v. *Blue Cross Hospital Service.* The issues in this case are purely legal, and perfectly suited to judicial resolution.

Accordingly, jurisdiction under 28 U.S.C. § 1331 lies for all of plaintiffs' claims in this action.

Plaintiffs assert that their right to be paid directly by the federal government stems from the original Medicare Act of 1965, at 42 U.S.C. § 1395g, stating:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less than monthly) . . . the amounts so determined . . .

The Act also provides that when any group or association of providers of services "wishes" to have payments made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement whereby that entity determines the amount, and makes payments to providers. 42 U.S.C. § 1395(h).

Based on these statutory provisions, and language from the legislative history, plaintiffs argue that providers have a right to have the Secretary determine the amount to be paid and make payments, and the option, if they so choose, to have this function performed by an intermediary. There is no doubt but that both the House and Senate Reports on the 1965 Medicare Act demonstrate an understanding that providers had the

option of dealing directly with the Secretary. S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. and Admin. News 1993; H.R. Rep. No. 213, 89th Cong. 147-148 (1965). The legislative history to the 1977 amendments also reflects this view. H.R. Rep. 393, 95th Cong., 1st Sess. 68 (1977).

Defendants do not deny that this was the original understanding of Congress, and their own past practice.[2] They assert, however, that they always had the authority to reassign direct dealing HHAs to intermediaries pursuant to § 1395-kk, giving the Secretary the authority to perform his functions under the Act by contract. They also rely on the 1977 amendment to § 1395h of the Act which allows the Secretary to "assign or reassign any provider of services" to an intermediary if he determines, after applying certain standards, criteria and procedures, "that such designation would result in more effective and efficient administration" of the program, 42 U.S.C. § 1395h(e)(1)-(3); and on the 1980 amendment which states: "[T]he Secretary shall designate regional agencies or organizations which have entered into agreements with him under this section to perform such functions with respect to home health agencies . . . in the region." § 930(s)(1), Omnibus Reconciliation Act of 1980, P.L. 96-499, Title I, 94 Stat. 2599 (December 5, 1980), 42 U.S.C. § 1395(h)(e)(4).

Defendants argue that since the 1977 amendment gave the Secretary the authority to both assign and reassign providers to intermediaries, he had the authority to assign intermediaries to direct-dealing HHAs, i.e. to make initial assignments to intermediaries. However, neither the legislative history nor the Secretary's own past practice support this interpretation. The 1977 amendments are entitled the Medicare-Medicaid Antifraud and Abuse Amendments," and the House Commit-

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[2] The Secretary's own regulations clearly state that providers may elect to receive payment "[d]irectly from the Administrator." 42 C.F.R. § 421.103 (1980).

tee Report makes clear that the purpose of the amendment in question was to authorize and require the Secretary to exercise more quality control over intermediaries, who were in a position of potential conflicts of interest in that their continued employment depended on the choice of the providers, and who had on occasion been found to be lax in performing their functions. The Secretary is permitted to override the provider's choice of intermediary, and required to develop standards, criteria and procedures to enable him to evaluate intermediaries' performance. H.R. Rep. No. 393, 95th Cong., 2d Sess. 68-70 (1977). None of this has any relevance to direct reimbursement. The Report states that the Secretary is not bound by a provider's choice in nominating an intermediary, *Id.* at 69, but never refers to providers who deal with ODR, or expresses any dissatisfaction with the quality of ODR's performance, or mandates any procedures to evaluate ODR's performance and compare it to that of intermediaries in order to make a decision on assignment or reassignment. It seems more probable that the reference to initial assignment in the statutory language refers to providers who have nominated an intermediary for the first time, and not to providers who are dealing with ODR and do not wish to nominate an intermediary. Either the defendants have themselves interpreted the language in this fashion until recently, or, at the very least, considered the wiser course of action to not disturb the choice of providers to deal with ODR. Their consistent policy until last year, as reflected in their own regulations, has been to afford providers an option to receive payment from ODR.

Defendants' interpretation of the 1977 amendment is also inconsistent with their position that § 1395-kk authorized them from the beginning to assign direct-dealing providers to intermediaries. The authority to assign providers to intermediaries not of their own choice given in the 1977 amendment was carefully circumscribed by requiring the Secretary to develop and utilize standards, criteria and procedures to determine whether the designation would result in more effective and efficient administration of the program, to furnish to the pro-

vider and the existing intermediary a full explanation of his reasons for that determination, and to afford the intermediary an opportunity for a hearing. 42 U.S.C. § 1395h(e)(l)-(3). An amendment which purportedly allows, under strictly defined procedures, the Secretary to do something he could always do anyway without those strictures defies reason. Either the 1977 amendment did not permit the reassignment of direct dealing HHAs, or the Secretary did not previously have the authority to do so under § 1395-kk.

As we have concluded, the 1977 amendment did not authorize the Secretary to reassign direct dealing HHAs. It remains to decide whether the 1980 amendment or § 1395-kk did so. The legislative history of the 1980 amendment is sparse. The House report reveals that the motive for the amendment was to standardize administrative and reimbursement practices of intermediaries, which were found to vary widely with respect to home health providers. In the words of the Committee,

> [t]his is largely attributable to the small proportion of an intermediary's medicare business that is devoted to this particular type of provider. As a consequence, little expertise is developed in this area and there is no way of making meaningful comparisons of the utilization and cost of various agencies. Consolidation of the medicare home health business among a smaller number of intermediaries will enable intermediaries to focus more resources on the administration of the benefit and develop uniform cost and performance criteria.

H.R. Rep. 1167, 96th Cong. 2d Sess. 368, *reprinted in* 1980 U.S. Code Cong. and Admin. News 5732. Nowhere is direct reimbursement mentioned, and the concerns expressed clearly do not apply to ODR, which currently serves approximately 469 HHAs. (Defendants' Statement of Material Facts Not in Dispute ¶ 4.) The only reference to ODR is the statement of the Conference Committee to the effect that:

> In requiring the designation of regional intermediaries for home health agencies, it is not the intent of the conferees that home health agencies would be precluded from contracting directly with the Health Care Financing Administration.

House Conference Report No. 1479, 96th Cong., 2d Sess. (1980). (ODR is under the umbrella of the Health Care Financing Administration (HCFA)).

Section § 1395h(e)(4), contrary to defendants' contention, does not so unambiguously require the Secretary to assign *all* HHAs, including those now dealing with ODR, to regional intermediaries as to justify overlooking such undeniably clear statements in the legislative history. The language of the amendment, (see p. 12, *supra*) does not refer to *all* HHAs. The ambiguity is clarified by consistent indications in the legislative history as well as the administrative practice over the past 15 years, which lead incontrovertibly to the conclusion that not only did the 1980 amendment not *require* the Secretary to assign direct-dealing HHAs to regional intermediaries,[3] but it also did not authorize him to do so. The language of the Conference Report unmistakably gives the election to the HHAs, who are not "precluded from contracting directly" with ODR.

In the face of continuing expressions of Congressional understanding that Medicare providers have the option to receive payment from the government directly, and the consistent 15 year practice on the part of the Secretary, defendants' argument that they always had the authority, under § 1395-kk, to contract out all of the services performed by ODR rings hollow. Defendants cannot point to any specific congressional expression of this interpretation, nor any indication that they themselves made this interpretation before 1980. See Plfts.' Ex. 32. In 1966, defendants requested a legal opinion from their Office of General Counsel, as to whether the Secre-

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[3] Although defendants have contended in their pleadings that they are required by the 1980 amendment to reassign direct-dealing HHAs, defendants' own General Counsel in a memorandum dated January 11, 1982, stated in reference to the 1980 Conference Report, ". . . the better reading of this language is that it merely indicated that the Secretary is not required to assign a direct dealing home health agency to a regional intermediary." Pltfs.' Ex. 36 at 5.

tary was "legally required to deal directly with providers electing to do so." The answer given by the Assistant General Counsel was that the Secretary did not have the right to designate an intermediary for a provider who did not elect to be served by an intermediary. Providers had the prerogative to have no intermediary. Certain ODR functions, for example, audit functions, however, could be performed by contract pursuant to § 1395-kk. Pltfs.' Ex. 33. While not an official declaration of agency policy, this statement, combined with the subsequent one and one-half decades' policy of allowing providers an election to deal with ODR, repromulgated in agency regulations as late as 1980, is strong evidence that the agency interpretation to which defendants now request the Court to afford deference is of recent vintage.

Under these circumstances, defendants' interpretation is not deserving of great deference, and we find, despite the general language of § 1395-kk appearing to permit the Secretary to contract out any of his functions under the Act, that he is not authorized to assign providers who have not elected to be so served to intermediaries. The more specific features of the statutory scheme, as we have seen, give providers who "wish" to do so the right to nominate an intermediary subject to the Secretary's approval, while retaining the option of dealing directly with the Secretary for others. The 1977 and 1980 amendments, while constricting the provider's right to select its own intermediary, were not intended to alter the status of direct-dealing providers. Congress has repeatedly expressed its understanding that providers have the option of dealing directly with the Secretary. Section 1395-kk cannot, suddenly, and contrary to Congressional understanding, be brought into service to allow defendants to abolish that option.

We express no opinion as to the desirability of requiring all home health agencies to deal with regional intermediaries, eliminating ODR's function in relation to them. Defendants are certainly free to attempt to persuade Congress to authorize such a policy. Congress may accept or reject that attempt. However, defendants may not implement this plan absent Congressional approval.

Having determined that defendants may not reassign direct dealing HHAs, plaintiffs' contention that the Secretary failed to apply the statutorily-mandated standards, criteria and procedures (42 U.S.C. § 1395h(f)) to the selection of the regional intermediaries remains relevant only to those HHAs who were previously served by intermediaries and are now required to transfer to the newly designated intermediaries. Although plaintiffs admit that the language of § 1395h(e)(4) (the 1980 amendment) excuses the Secretary from making a determination under the regulatory standards, criteria and procedures as to whether designating a regional intermediary will result in ". . . the more effective and efficient administration" of the Medicare program,[4] plaintiffs nonetheless maintain that defendants are still bound by § 1395h(b) to apply the standards, criteria and procedures developed under § 1395h(f) to determine that the designation of the regional intermediaries is "consistent" with the effective and efficient administration of the program. However, § 1395h(b) applies by its terms to entering or renewing agreements with intermediaries, while the 1980 amendment requires the Secretary to designate regional intermediaries who already have agreements with the Secretary, (i.e., existing intermediaries). Accordingly, plaintiffs' claim under § 1395(b) fails. The Secretary has not violated this provision or its regulatory implementation in selecting the regional intermediaries for those HHAs who choose to be served by intermediaries.

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[4] § 1395(e)(4) provides that regional intermediaries shall be designated "[n]otwithstanding subsections (a) and (d) and paragraphs (1), (2) and (3) of this subsection," which include the provisions requiring a determination by the Secretary, using the mandated standards, criteria and procedures to determine that an assignment or reassignment to an intermediary would result in the more effective and efficient administration of the program, and requiring the Secretary to provide an explanation of his determination to the provider and the existing intermediary and to afford the intermediary a hearing. 42 U.S.C. § 1395h(e) (1), (2) and (3).

Plaintiffs' final contention is that defendants failed to follow the procedures mandated by the APA for rulemaking in promulgating their policy. Again, as defendants may not reassign direct-dealing HHAs at all under the current statutory scheme, this claim only has relevance to HHAs previously dealing with intermediaries. There is no dispute but that defendants were required by the 1980 Amendment to designate regional intermediaries for HHAs who choose to deal with intermediaries. The regional intermediaries were selected from among existing intermediaries, thus some HHAs remained with the same intermediaries, while others have been or will be transferred. Some members of plaintiff National Association of Home Health Agencies are in the latter category. Plaintiffs allege that this group (along with those trasferring from ODR) is seriously affected by the timing of the transition and by the designation of particular intermediaries, in that the speed of the transition and the lack of capacity of some of the designated intermediaries have already or may later result in delays in payment and other inefficiencies. According to affidavits submitted by some of the plaintiffs, these conditions impact the plaintiffs economically, and could result in forcing them to reduce staff, eliminate services, or go out of business entirely. Pltfs.' Exs. 14 at 3, 21, 23, 24, 28, and 40. They contend that the administrative instruction here fits the APA definition of a "rule,"[5] and is a "substantive rule" subject to the notice and comment procedures of 5 U.S.C. § 553 because it has a substantial impact upon them. See *Brown Express, Inc.* v. *United States*, 607 F.2d 695 (5th Cir. 1979).

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[5] "[R]ule means the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency and includes the approval or prescription for the future of rates, wages, corporate or financial structures or reorganizations thereof, prices, facilities, appliances, services or allowances therefor or of valuations, costs, or accounting, or practices bearing on any of the foregoing" 5 U.S.C. § 551(4).

Defendants, while not claiming to have followed the APA procedures of Federal Register notice of proposed rules, opportunity for interested persons to comment, consideration of the comments, and publication of the final rules with a concise general statement of their basis and purpose 30 days before their effective date, contend that the December 1981 instruction is not a rule, and that even if it were it would be exempt from notice and comment procedures. It is not a rule, they assert, because they have a mandatory duty to designate intermediaries, and there are no policy options on which to comment. The Secretary has not engaged in rulemaking, but has acted to carry out a nondiscretionary duty. This statement does not withstand scrutiny. As plaintiffs have pointed out, defendants were given the discretion to delineate the regions (they chose statewide regions), select the regional intermediaries from among existing intermediaries, and schedule the implementation of the transition. Defendants also perceived policy options in their implementation of the assignment of regional intermediaries. In their September 1980 intermediary letter,[6] opinions and recommendations were sought from intermediaries as to what defendants considered "major issues" relevant to the proposed policy. "1. Should there be any exceptions to the proposal for one intermediary per State? . . . 2. Should there be a separate treatment for multi-provider chains? . . . 3. Should the Office of Direct Reimbursement be available for servicing local Government operated home health agencies? . . . 4. What is the most effective way for making the transition to a Statewide intermediary?" Exhibit A to the January 12, 1982 Affidavit of Tera S. Younger. Any number of

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[6] This letter is dated prior to the enactment of the 1980 amendment. Defendants were then considering the designation of regional intermediaries pursuant to their purported authority under the 1977 amendment. The 1980 amendment, although requiring the Secretary to implement the option of designating regional intermediaries, did not circumscribe the Secretary's discretion in the areas discussed in the letter.

policy issues could have been subject to comment. For example, plaintiffs' concern that Medicare will not fully compensate the cost of the transition could have been formally examined and addressed before the transition began. (Plaintiffs were obviously uncertain about Medicare's policy on this matter at the commencement of this lawsuit). Doubts related to the regional intermediaries' ability to timely process claims during the transition and the HHAs' resulting cashflow problems could have been addressed. Plaintiffs as affected parties undoubtedly had opinions as to the most effective, and least costly way to accomplish the transition. This is not to say that some input on these issues was not received and considered by defendants. But it was not done in accordance with APA procedures.

The December, 1981 instruction is an agency statement of general applicability and future effect designed to implement law, and therefore a rule under the APA. It is not an interpretive or procedural rule excepted from notice and comment requirements. It is a substantive rule because it substantially impacts the rights and obligations of affected parties. *Chrysler Corp.* v. *Brown*, 441 U.S. 281, 301-302 (1979); *Batterton* v. *Marshall*, 648 F.2d 694 (D.C. Cir. 1980).

Defendants next argue that notice and comment procedures were not required in this case because plaintiffs, as demonstrated by their own exhibits (Pltfs.' Ex. 7, 12, and 27) had actual notice of the policy throughout the course of its development, and did submit comments. However, the fact that some plaintiffs had learned of the proposed policy and submitted unsolicited comments does not prove that all of the plaintiffs had actual notice, or that the notice they had adequately described the proposed rule for APA purposes.

In fact, defendants impermissibly relied on word of mouth and third parties to afford plaintiffs notice. The August 1980 intermediary letter proposing the policy was circulated to intermediaries and HCFA components, not HHAs, for comment. January 12, 1982 Affidavit of Tera S. Younger at ¶ 6.

Defendants subsequently did meet with plaintiff National Association of Home Health Agencies (NAHHA) to discuss the proposal and request its help in soliciting individual HHA comments. *Id.* News of the proposed policy appeared in NAHHA's August, 1980 Newsletter, and defendants did receive comments from HHAs on the proposed policy. However, there was no guarantee, and there is no proof now, that all affected HHAs received actual notice. In fact, some representatives of HHAs have averred in affidavits in this case that they did not receive notice. Pltfs.' Ex. 16, 19, 29. Constructive notice through national associations and trade journals is not adequate. The Federal Register is the only acceptable form of constructive notice under the APA. *Rodway* v. *United States Department of Agriculture*, 514 F.2d 809, 815 (D.C. Cir. 1975). In any case, the August, 1980 letter did not contain a fully-formulated proposal.

In August of 1981, HCFA provided a more detailed account of its policy to national HHA associations, and to intermediaries, who were asked to forward copies to the HHAs they served. Younger affidavit at ¶ 9 and Exhibit E to the affidavit. Again, a request to a third party to provide notice does not meet the requirement of actual notice. Furthermore, this letter announced an already formulated policy, not a proposed policy concerning which comments would be considered. The December 1981 instruction, which also only reached HHAs by way of their intermediaries, merely described the action taken, and solicited no comments.

Whether or not defendants were excused from publication of the proposed rule in the Federal Register, they were still obligated to consider the comments and publish a final rule with a concise general statement of its basis and purpose 30 days before its effective date. Although defendants claim to have considered the comments received, they did not formally address them and provide the statement of basis and propose required in the Federal Register.

Defendants must address the discretionary aspects of the transition to regional intermediaries in a proposed rule, pub-

lished in the Federal Register, solicit comments, consider the comments, and publish the final rule with the required statement.

Although it is regrettable that the transition process must be interrupted in mid-course, we have no choice but to require compliance with the law.

An appropriate judgment accompanies this Memorandum Opinion.

/s/ JOYCE HENS GREEN
Joyce Hens Green
United States District Judge

March 10, 1982

United States District Court

FOR THE DISTRICT OF COLUMBIA

Civil Action No. 81-3160

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES, *et al. Plaintiffs,*

v.

RICHARD S. SCHWEIKER, *et al., Defendants.*

FILED
March 10, 1982
JAMES F. DAVEY, Clerk

JUDGMENT

It is this 10th day of March, 1982, hereby

ORDERED, that declaratory judgment is entered in favor of plaintiffs National Association of Home Health Agencies; Home Health Services and Staffing Association; Upjohn Healthcare Services, Inc.; Alabama Department of Public Health; Barber County Community Home Health Agency; Chataugua County Home Health Agency; Comprehensive Home Health Services; Elk County Home Health Agency; Franklin County Nursing Service; Golden Belt Home Health Services; Harvey County Home Health Agency; Home Health Services of Lake County; Home Health Services of Tarrant County, Inc.; Hub City Home Health Services, Inc.; Kiowa Comanche Home Health Agency; Koochiching County Nursing Service; Lake of the Woods Nursing Service; Lincoln, Lyon, Murray & Pipestone Community Health Services; Medical Home Care Services; Mediserv Home Health Agency; Mid-Peninsula Health Services, Inc.; Mitchell County Home Health Agency; Mountain and Valley In-Home Services, Inc.; Nassau County Department of Health; Pottawatomie City Home Health Agency; Roseau County Nursing Service; San

Diego Hospice Corporation; San Francisco Home Health Services; Santa Barbara Visiting Nurse Association; South Mississippi Home Health & Rehabilitation Agency, Inc.; Trend Home Health Agency; Trico Home Health Services, Inc.; Tri-County Home Health Care; Visiting Nurse Association of Alameda County; Visting Nurses Association of Greater Chesterfield; Visiting Nurse Association of Northern Virginia; VNA of San Diego; VNA of San Francisco; VNA of Southwest Louisiana, Inc.; VNA of Ware County; and VNS of Verdugo Hills, and against defendants Richard S. Schweiker, Secretary, United States Department of Health and Human Services and Carolyne K. Davis, Administrator of the Health Care Financing Administration, United States Department of Health and Human Services, to the effect that defendants' December 8, 1981 instruction to intermediaries violates the Medicare Act insofar as it assigns plaintiffs who choose to deal with defendants' Office of Direct Reimbursement to regional intermediaries for the purpose of Medicare reimbursement determinations and payment, and it is

FURTHER ORDERED, that defendants are permanently enjoined, absent new statutory authorization, from requiring plaintiffs, absent their election to do so, to seek Medicare reimbursement determinations and payment from other than defendants' Office of Direct Reimbursement, and it is

FURTHER ORDERED, that judgment is entered in favor of defendants Richard S. Schweiker, Secretary, United States Department of Health and Human Services and Carolyne K. Davis, Administrator of the Health Care Financing Administration, United States Department of Health and Human Services and against plaintiffs National Association of Home Health Agencies; Home Health Services and Staffing Association; Upjohn Healthcare Services, Inc.; Alabama Department of Public Health; Barber County Community Home Health Agency; Chataugua County Home Health Agency; Comprehensive Home Health Services; Elk County Home Health Agency; Franklin County Nursing Service; Golden Belt Home Health Services; Harvey County Home Health

Agency; Home Health Services of Lake County; Home Health Services of Tarrant County, Inc.; Hub City Home Health Services, Inc.; Kiowa Comanche Home Health Agency; Koochiching County Nursing Service; Lake of the Woods Nursing Service; Lincoln, Lyon, Murray & Pipestone Community Health Services; Medical Home Care Services; Mediserv Home Health Agency; Mid-Peninsula Health Services, Inc.; Mitchell County Home Health Agency; Mountain and Valley In-Home Services, Inc.,; Nassau County Department of Health; Pottawatomie City Home Health Agency; Roseau County Nursing Service; San Diego Hospice Corporation; San Francisco Home Health Services; Santa Barbara Visiting Nurse Association; South Mississippi Home Health & Rehabilitation Agency, Inc.; Trend Home Health Agency; Trico Home Health Services, Inc.; Tri-County Home Health Care; Visiting Nurse Association of Alameda County; Visiting Nurses Association of Greater Chesterfield; Visiting Nurse Association of Northern Virginia; VNA of San Diego; VNA of San Francisco; VNA of Southwest Louisiana, Inc.; VNA of Ware County; and VNS of Verdugo Hills, on plaintiffs' claim that the Secretary failed to comply with 28 U.S.C. § 1395(b) in the designation of regional intermediaries, and it is

FURTHER ORDERED, that judgment is entered in favor of plaintiffs National Association of Home Health Agencies; Home Health Services and Staffing Association; Upjohn Healthcare Services, Inc.; Alabama Department of Public Health; Barber County Community Home Health Agency; Chatauqua County Home Health Agency; Comprehensive Home Health Services; Elk County Home Health Agency; Franklin County Nursing Service; Golden Belt Home Health Services; Harvey County Home Health Agency; Home Health Services of Lake County; Home Health Services of Tarrant County, Inc.; Hub City Home Health Services, Inc.; Kiowa Comanche Home Health Agency; Koochiching County Nursing Service; Lake of the Woods Nursing Service: Lincoln, Lyon, Murray & Pipestone Community Health Services; Medical Home Care Services; Mediserv Home Health Agency; Mid-Peninsula Health

Services, Inc.; Mitchell County Home Health Agency; Mountain and Valley In-Home Services, Inc.; Nassau County Department of Health; Pottawatomie City Home Health Agency; Roseau County Nursing Service; San Diego Hospice Corporation; San Francisco Home Health Services; Santa Barbara Visiting Nurse Association; South Mississippi Home Health & Rehabilitation Agency, Inc.; Trend Home Health Agency; Trico Home Health Services, Inc.; Tri-County Home Health Care; Visiting Nurse Association of Alameda County; Visiting Nurses Association of Greater Chesterfield; Visiting Nurse Association of Northern Virginia; VNA of San Diego; VNA of San Francisco; VNA of Southwest Louisiana, Inc.; VNA of Ware County; and VNS of Verdugo Hills, and against defendants Richard S. Schweiker, Secretary, United States Department of Health and Human Services and Carolyne K. Davis, Administrator of the Health Care Financing Administration, United States Department of Health and Human Services on plaintiffs' claim that defendants' promulgation of the policy requiring Home Health agencies to be served by designated regional intermediaries is subject to the notice and comment procedures mandated at 5 U.S.C. § 553, and it is

FURTHER ORDERED, that within 30 days of this date, defendants shall publish in the *Federal Register* a proposed rule, in accordance with the Memorandum Opinion of this date, and solicit comments thereon from interested parties. Until the procedures mandated in 5 U.S.C. § 553 are completed, Home Health Agencies shall have the option of obtaining Medicare cost reimbursement determinations and payment from the organizations or agencies which served as their intermediaries prior to the designation of regional intermediaries.

/s/ JOYCE HENS GREEN
Joyce Hens Green
United States District Judge

APPENDIX D

United States District Court

FOR THE DISTRICT OF COLUMBIA

Civil Action No. 81-3160

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES, *et al. Plaintiffs,*

v.

RICHARD S. SCHWEIKER, *et al., Defendants.*

FILED
March 1, 1982
JAMES F. DAVEY, Clerk

TEMPORARY RESTRAINING ORDER

This matter, having come before this Court upon the complaint filed by plaintiffs, plaintiffs' motion for a temporary restraining order pursuant to Rule 65(b) of the Federal Rules of Civil Procedure, plaintiffs' memorandum in support of that motion, the written declaration submitted by the defendants, and oral argument by both parties, for the reasons stated orally on the record this date, it is this 1st day of March, 1982, hereby

ORDERED, that defendants and their officers, agents, servants, employees, attorneys, and those persons in active concert with them shall not, for a period of 10 days or until this Court can render a final determination in this action if sooner, require plaintiffs to submit requests for Medicare reimbursement to other than the defendants' Office of Direct Reimbursement; and said Office shall continue to process those claims in the usual manner during that time period.

This Order is issued at 2:22 p.m. March 1, 1982 and shall expire, unless extended, at 2:22 p.m. March 10, 1982.

Security will be required of the plaintiffs in the amount of $100.00 cash or surety.

/s/ JOYCE HENS GREEN
Joyce Hens Green
U. S. District Judge

APPENDIX E

42 U.S.C. § 1395g. Payments to providers of services; conditions; amount; payments under assignment or power of attorney

(a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments;

. . .

42 U.S.C. § 1395h. Use of public or private agencies or organizations to facilitate payment to providers of services—Authorization for agreement by Secretary for implementation; scope of agreement

(a) If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to the provisions of section 1395*oo* of this title and to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers (and to providers assigned to such agency or organization under subsection (e) of this section), and for the making of such payments by such agency or organization to such providers (and to providers assigned to such agency or organization under subsection (e) of this section).

. . .

42 U.S.C. § 1395kk. Administration

(a) Except as otherwise provided in this subchapter and in the Railroad Retirement Act of 1974, the insurance programs established by this subchapter shall be administered by the Secretary. The Secretary may perform any of his functions under this subchapter directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

APPENDIX F

42 C.F.R. § 421.103 Option available to providers.

A provider may elect to receive payment for covered services furnished to Medicare beneficiaries:

(a) Directly from the Administrator;

or

(b) Through an intermediary, when both the Administrator and the intermediary consent.

42 C.F.R. § 421.104 Nominations for Intermediary.

(b) Nomination by nonmembers or nonconcurring members. Providers that nonconcur in their association's nomination, or are not members of an association, may:

(1) Form a group of 2 or more providers for the specific purpose of nominating an intermediary, in accordance with provisions of paragraph (a) of this section; or

(2) Exercise their right to receive payment directly from the Administrator in accordance with § 421.103.

33 Fed. Reg. 11277-78 (August 8, 1968)

20 C.F.R. § 405.651 Nomination of agency or organization as "intermediary": contractual undertakings with intermediaries.

(a) Under section 1816 of the Act, groups of providers or associations of providers, may nominate on behalf of the members of such group of association, a national, State, or other public or private agency or organization for the purpose of entering into an agreement with the Secretary providing for the determination of amounts payable under title XVIII, and the making of such payments, by such agency or organization to providers of services. A member of a group or association may, however, deal directly with the Secretary rather than through an intermediary. The nomination of an agency or

organization by a group or association of providers of services (see § 405.653); shall not be binding on any member of such group or association if such member notifies the Secretary of its desire not to be bound by such nomination.

20 C.F.R. § 405.654 Election to deal through a nominated agency or organization or to deal directly with the Secretary.

A provider which is not a member of a group or association which has nominated an intermediary or a nonconcurring member of a group or association of providers of services, may with the consent of the Secretary and an agency or organization which has entered into an agreement with the Secretary, elect such agency or organization to determine the amount of and make payment to such provider under the provisions, described in Subpart A of this part or, elect to receive payment directly from the Secretary. This procedure is also available to any provider of services which has forwarded notice of intent to withdraw its concurrence in the nomination or its election of a particular agency or organization (see § 405.656).

APPENDIX G

medicare
Part A Intermediary Letter

Department of Health
and Human Services

Health Care Financing
Administration

Transmittal No. A-81-32

Date December 1981
BPO-P13

SUBJECT: Designation of Regional Intermediaries to Serve Freestanding Home Health Agencies—ACTION

Intermediaries have now been selected to serve freestanding home health agencies (HHAs) as required by the Omnibus Reconciliation Act of 1980. As you recall, I.L. A-81-21 transmitted a briefing paper which outlined the Health Care Financing Administration's (HCFA) final plan for implementing this legislation.

Attachment 1 identifies designated intermediaries for each State and discusses some implementation issues. Please forward one copy of this paper to each of the HHAs you now serve (both freestanding and provider-based) using the draft language in Attachment 2 as appropriate.

Attachment 3 provides guidelines on change of intermediary activities connected with the implementation of HHA intermediaries. Your HCFA Regional Offices will contact you to set up a meeting with affected HHAs and intermediaries to go over these plans.

Questions concerning this letter should be referred to your servicing HCFA regional office.

3 Attachments

Designation Of Regional Medicare Intermediaries To Serve Freestanding Home Health Agencies

The Health Care Financing Administration (HCFA) has now selected intermediaries to serve freestanding home health agencies (HHAs) as required by the Omnibus Reconciliation Act of 1980. Exhibit 1 lists the organizations which have been designated for each State.

BACKGROUND

P.L. 96-499 directed the Department of Health and Human Services (DHHS) to designate regional intermediaries to serve freestanding HHAs. This legislation was an outgrowth of concern about fraud and abuse resulting in overpayments to HHAs, as well as more general interest in improving contractual arrangements with the private sector for administering the Medicare program. The purpose of the legislative provision was to assure that each intermediary would have a sufficient number of HHAs to develop expertise in claims adjudication and audit activities and give sufficient priority attention to their HHA workload.

In August of 1981, HCFA notified home health agencies, intermediaries, and other interested parties of its plans to designate one intermediary to serve freestanding HHAs in each state. After announcement of its plans for implementing this legislation, HCFA used a structured process to select an HHA intermediary for each State. Selection criteria included past performance, current volume of HHA workload, and ability to assume the additional workload. Input solicited from HHAs was considered in those States where a more than one intermediary currently serves a significant volume of HHAs.

IMPACT

We believe the designation of the regional HHA intermediaries listed in Exhibit 1 will achieve the goal of both Congress and HCFA to improve the administration of the home health benefit under the Medicare program. Consolidating the workload of freestanding HHAs under a single intermediary in each

State should improve management and control of coverage and reimbursement determinations for HHAs. The use of State intermediaries will also facilitate intermediary onsite review of HHAs which has proven to be a significant tool for assuring improved reimbursement determinations and controlling overutilization and overpayments which have been of concern to HCFA and the Congress in the past. Consistent application of Medicare policies with respect to HHAs within each State will enhance delivery of necessary services by providing predictability for providers, beneficiaries and the health care community.

Approximately 29 percent of HHAs participating in the Medicare program will be reassigned to another intermediary as a result of implementation of this legislation. The number of intermediaries serving freestanding HHAs will be reduced from 72 to 49 as a result of this action. Freestanding HHAs in 17 States are already served by the designated organization, thus no reassignments will occur in these States. (No HHA intermediary will be designated for Puerto Rico and the Virgin Islands because of the proposed competitive procurement to select a single organization to serve their entire Medicare workload.) In many additional States, only a minimal number of agencies will be affected since the designated intermediary already serves the majority of HHAs in the State. In only 12 States will there be a major shift of HHAs to a new intermediary (Alabama, Arizona, Arkansas, California, Florida, Ohio, Pennsylvania, South Carolina, Texas, Virginia, Washington, West Virginia). The following implementation procedures are designed to assure a smooth transition to the new intermediaries.

IMPLEMENTATION

HCFA will work closely with intermediaries and HHAs throughout the implementation process to assure a smooth transition and no interruption in cash flow. In the States with a significant volume of HHA transfers, committees consisting of HCFA RO, intermediary and State HHA association repre-

sentatives will be established to coordinate transition activities. In other affected States, ROs will keep in touch with intermediaries and reassigned providers to discuss implementation issues.

Freestanding HHAs not currently dealing with the designated intermediary in their State will be transferred to that organization beginning on January 1, 1982, based on provider cost reporting year ending dates. (For example, a freestanding HHA with an accounting year ending December 31, 1981, will be transferred to the new intermediary on January 1, 1982.) Our data indicates that the majority of HHA reassignments will occur on January 1, 1982 (38 percent), July 1, 1982 (31 percent), and October 1, 1982 (15 percent).

The designated intermediary will assume responsibility for bill processing on the effective date of the transfer, as well as audit and cost report settlement of the cost report which begins on that date. The current intermediary will continue to be responsible for auditing and settling the cost report for the period ended just before the transfer. The transition committee will assure that there is no interruption in cash flow to providers. PIP rates and reimbursement rates will be continued "as is" for the initial cutover period until the designated intermediary becomes familiar with new HHAs' accounting systems. HCFA ROs will closely monitor transition activities and operation of designated intermediaries to assure the establishment of effective intermediary/HHA relationships.

Because of the short time before implementation, the transfer of bill processing for HHAs reassigned effective January 1, 1982, may be delayed if deemed necessary by the transition committee to promote a smooth transfer. However, responsibility for cost report settlement would still be transferred effective January 1, 1982.

The transfer of HHAs billing the Office of Direct Reimbursement on an automated basis will be timed on an individual basis to assure that the designated State intermediary can handle the HHAs' billing needs. Designated intermediaries will be

asked to contact any automated billing HHAs in their service area to work on a mutually agreeable billing system (whether telecommunications or magnetic tape) which meets HCFA's data requirements. This flexibility should be able to serve the needs of both HHAs and HCFA.

HCFA will evaluate requests from multi-State HHA chains to have all their audit and settlement work done by a single intermediary on a case-by-case basis. Approval will be based on whether the degree of centralization of the chain organization would make such a deviation efficient and effective.

PROBLEM RESOLUTION PROCEDURE FOR HHAS

We believe that the vast majority of reassigned HHAs will be able to establish good working relationships with designated intermediaries. However, we recognize that there may be a limited number of cases in which a given HHA has a problem which they are unable to resolve with their designated intermediary. HCFA ROs will investigate such cases and resolve problems. Such problems and their resolution will be used to evaluate intermediary performance and make decisions about continuing designations.

APPENDIX H

Parties To This Proceeding And Their Member Organizations And Parent Companies

National Association of Home Health Agencies

Home Health Services and Staffing Association

Upjohn Healthcare Services

The Upjohn Company

Alabama Department of Public Health

Barber County Community Home Health Agency

Chataugua County Home Health Agency

Comprehensive Home Health Services

Elk County Home Health Agency

Franklin County Nursing Service

Golden Belt Home Health Services

Harvey County Home Health Agency

Home Health Services of Lake County

Home Health Services of Tarrant County, Inc.

Hub City Home Health Services, Inc.

Kiowa Comanche Home Health Agency

Koochiching County Nursing Service

Lake of the Woods Nursing Service

Lincoln, Lyon, Murray, & Pipestone Community Health Services

Medical Home Care Services

Mediserv Home Health Agency

Mid-Peninsula Health Services, Inc.

Mitchell County Home Health Agency

Mountain and Valley In-Home Services, Inc.

Nassau County Department of Health

Pottawatomie City Home Health Agency

Roseau County Nursing Service

San Diego Hospice Corporation

San Francisco Home Health Services

Santa Barbara Visiting Nurse Association

South Mississippi Home Health & Rehabilitation Agency, Inc.

Trend Home Health Agency

Trico Home Health Services, Inc.

Tri-County Home Health Care

Visiting Nurse Association of Alameda County

Visiting Nurses Association of Greater Chesterfield

Visiting Nurse Association of Northern Virginia

VNA of San Diego

VNA of San Francisco

VNA of Southwest Louisiana, Inc.

VNA of Ware County

VNS of Verdugo Hills

Visiting Nurse Association of Springfield, MA

International Homemakers

Community Nurse Association

District Nursing Association

Westport Home Health Agency

Lakes Region Community Health

Androscoggin Home Health Service

Salisbury Public Health Nursing

Family Services - Woodfield

St. Luke's Home Care Program

Condado Home Care Program, Inc.

Hospital Sin Paredes, Inc.

Bayonne Visiting Nurse Ass'n.

Patient Care Medical Services

MCOSS Nursing Services, Inc.

Gloucester County Visiting Nursing Association, Inc.

Visiting Nurse Service of New York

Long Island College Hospital

The Brooklyn Hospital

The Methodist Hospital Home Care

Visiting Nurse Association of Brooklyn

Maimonides Medical Center

Metropolitan Jewish Geriatric

Jewish Hospital and Medical Center Home Health Agency

Visiting Homemaker Services

Visiting Nurse Association of Buffalo

Visiting Nurse Association of Rochester & Monroe Counties

South Hills Health Systems

Northwest Allegheny Home Health Care Agency

Butler Home Health Care Agency of Erie County

North Penn Home Health Agency

Visiting Nurse Associaton of Carlisle Hospital

Visiting Nurse Association of Mechanicsburg, PA

Home Care Services Agency

Visiting Nurse Association of Hanover, PA

Visiting Nurse Association of Spring Grove, PA

Columbia Montour Home Health Service

Home Health Care of Bethlehem, PA

Visiting Nurse Association of Bethlehem, PA

Chester Medical Center Holy Redeemer Visiting Nurse Association

Adventist Home Health Service

Holy Cross Hospital Home Health Care Service

Staff Builders Home Health Care

West Baltimore Community Health Care Corporation

Good Samaritan Hospital

HomeCall, Inc.

Bur Home Health Services

Department of Nursing, Old Dominion University

Maryview Hospital

Toledo District Nurse Ass'n.

Deaconess Home Health Agency

Visiting Nurse Service, Inc.

Carroll County Visiting Nurse Association

Cinciannati Health Dept.

Visiting Nurse Association of Dayton, OH

United Health Program - Calumet Huntington County Home Health Agency

Visiting Nurse Association of Southwest Indiana

Visiting Nurse Association of St. Clair County

Monroe County Health Dept.

Michigan Cancer Foundation Svc.

Visiting Nurse Association of Metropolitan Detroit

Lapeer County Health Dept.

Central Michigan District of Health

Shiawassee County Health Dept.

In-Home Health Care Service

St. Joseph District of Health

Jackson County Health Dept.

Trinity Memorial Hospital

We Care Nursing Service

Outreach Home Health Service

Grant County Nurses

Green Bay Visiting Nurse Association

Wausau Visiting Nurse Association

Community Health & Social Services

Metro Home Health Care, Inc.

Ebenezer Society

North Memorial Medical Center

Dept. of Community Services

Alexian Brothers Medical Center

Lake Forest Hospital Home Care

In Home Health Care Service of Suburban Chicago North, I

In Home Health Care Service of Suburban Chicago West

Country Care, Inc.

Home Health Service

United Homecare, Ltd.

Bodimetric Health Services, Inc.

Chicago Center Memorial Hospital

Rogers Park Home Health Care

Visiting Nurses Association of Rockford, IL

Rock Island County Health Dept.

Peoria City/County Health Dept.

Home Health Services of Mercy

Lincolnland Visiting Nurse Ass'n.

St. Francis Hospital

Visting Nurse Association of St. Clair County

Home Health Service of St. Joseph's Hospital

Lawrence County Health Dept.

Good Samaritan Hospital

Tip of Illinois Health Svc.

Metropolitan Health Services

Lee County Cooperative Clinic

CMH Home Health Agency

Home Health Care Agency, Inc.

Valley View Hospital

Visiting Nurse Associaton of Dallas

Red River Valley Home Health Agency

Mobile Nurses, Inc.

East Texas Home Health Agency

Home Health-Home Care, Inc.

North Central Texas Home Health Agency, Inc.

Wichita Home Health Service

West Texas Home Health Agency

Home Health Agency of Texas, Inc.

Waco-McLennan County Health Center

Nurses PRN, Inc.

Visiting Nurse Association of Houston

Logos Nursing Personnel Service

Visiting Nurse Association of Montgomery County, TX

Home Health-Home Care, Inc.

Visiting Nurse Association of Brazoria County, TX

Home Health-Home Care, Inc.

Upjohn Health Care Services, Inc.

Home Health-Home Care, Inc.

Port Arthur Home Health Service

Texas Home Health, Inc.

Upjohn Health Care Services, Inc. of Beaumont, TX

Beaumont Home Health Service

Home Health-Home Care, Inc. of Brenham, TX

Victoria Home Health Agency

Hill Country Home Health Agency

Home Health-Home Care, Inc. of San Antonio, TX

Valley Home Health Agency

Homemakers East Texas - DBA Upjohn Healthcare

Girling Health Care, Inc.

West Texas Home Health Agency

Good Samaritan Health Care, Inc.

West Central Texas Home Health

Hospital Home Health Care

Albuquerque Visiting Nurse Service

Ames Visiting Nurse Service

Cass County Memorial Hospital

Dubuque Visiting Nurse Ass'n.

Community and Home Health Services Agency

Public Health Nursing Ass'n.

Visiting Nurse and Homemaker Service

Home Care Program of Greater St. Louis

Visiting Nurse Association of Greater St. Louis

Northeast Missouri Home Health Agency

Independence Home Health Agency

John Knox Home Health Agency

Spelman Memorial Hospital

Johnson County Community Health Service

Catholic Charities of Kansas City

Methodist Care Center Home Care

Visiting Nurse Association of Greater Kansas City

St. Francis Hospital Home Health Agency

Sac Osage Home Health Agency

Nevada City Hospital Home Health Agency

St. John's Medical Center

McDonald County Home Health Agency

Missouri River Home Health Agency

Columbia Visiting Nurse Association

Meramec Home Health Agency

Lake Ozard Area Home Health Agency

Riverways Home Health Agency

Visiting Nurse Association

OACAC

Home Health Agency of Catholic

VNA of Kansas & Wyandotte Counties

Topeka-Shawnee County Health Department

Harper County Home Health Agency

Susan B. Allen Memorial Hospital

Harvey County Home Health Agency

Dept. of Community Health

Trinity Home Health Agency

Burt-Washington Home Health Care

Home Health Agency of Omaha

Lutheran Medical Center

Archbishop Bergen Mercy Hospital

State Health Department (NE)

Tabitha Home Health Care

St. Francis Home Health

Good Samaritan Hospital

Home Health Agency of Mary Lan

Phelps Memorial Health Center

Sacred Heart Hospital

Richland County Health Dept.

Missoula Home Health Agency

Ravalli County Public Health

St. Joseph Home Health Care Agency

Flathead City-County Home Health

Visiting Nurse Association of the Denver Area, Inc.

Dominican Sisters of the Sick and Poor

Jefferson County Health Dept.

Visiting Nurse Association of Boulder County, Inc.

Larimer County Visiting Nurse Association

Rehabilitation and Visiting Nurse Association

Colorado Springs Visiting Nurse Association

DePaul Hospital Home Care Service

Community Home Health Care Agency

Visiting Nurse Service, Inc.

Good Samaritan Hospital Home Health Care Service

Scottsdale-St. Luke's Home Health Agency

Coordinated Home Health Service

Payson Home Health Agency

Home Health Agency of Pima County

Yavapai County Home Health Agency

Sunrise Home Health Care Program

Nevada Home Health Services, Inc.

Kaiser Permanent Medical Care

Visiting Nurse Association of Los Angeles, Inc.

Hospital Home Health Care Agency

City of Hope Home Health Agency

Verdugo Hills Visiting Nurses Association

National In-Home Health Services

Visiting Nurses Association of San Gabriel Valley

Continuity of Care Home Health

Total Care, Inc.

Visiting Nurse Association of San Diego County

Allied Home Health Agency

Allied Home Health Association

Home Care Department

Town & Country Home Nursing Service

Visiting Nurse Association of Orange County

Home Health Agency of San Luis Obispo

Saint Agnes Home Care Agency

Fresno Community Hospital and Center—Home Health Service

Salinas Valley Visiting Nurse Association

Monterey Peninsula Visiting Nurse Association, Ltd.

Visiting Nurse Association of San Francisco, Inc.

Mt. Zion Hospital & Medical Center

San Francisco Home Health Service

Vesper Home Care

Home Health and Counseling Service

Visiting Nurse Association Serving Alameda County

Visiting Nurse Association of Santa Cruz County

South Bay Home Health Agency

Alexian Brothers Hospital Home Health Care Service

Home Health Service/Visiting Nurse Association of San Joaquin

Humboldt County Home Health Agency

Community Home Health Services

Straub Clinic and Hospital, Inc.

Southeastern District Health Dept.

District 7 Health Dept.

Home Health Center/Mercy Medical Center

Community Home Health, Inc.

N. Idaho Home Health

Panhandle Health District #1

The Dallas General Hospital

Clatsop County Home Health Service

Yamhill County Home Health Agency

Portland Visiting Nurse Association

Portland Adventist Home Health Agency

Marion County Health Dept.

Home Health Agency of Salem, OR

Bay Area Hospital Home Health

Harney County Home Health Agency

Seattle/King County Visiting Nurse Service

Community Home Health Care

Visiting Nurse Association of Snohomish County

Community Homewell

Good Samaritan Hospital and Rehabilitation Center

Hospice of Tacoma

Home Health Program of Yakima, WA

N.E.W. Health Programs

Spokane Visiting Nurse Association

St. Luke's Home Health Agency

Anchorage Home Health Agency

Cabarrus County Home Health Agency

Lincoln County Home Health Agency

Cleveland Home Health Agency

Total Care, Inc.

Scotland County Home Health Agency

Caldwell County Home Health Agency

Visiting Health Professionals

Good Shepherd Home Health Agency

South Carolina Department of Health

Sea Island Comprehensive Health Care Corporation

Floyd Home Health Agency

Visiting Nurse Association of Metropolitan Atlanta

Ogeechee Home Health Agency

Mountain Home Health Agency

St. Mary's Home Health Agency

CSRA Home Health Agency, Inc.

Health Help Services, Inc.

District XV Home Health Agency

Chattahoochee Valley Home Health Agency

St. Vincent's Medical Center

Florida Home Health Services

Suncoast Home Health Services

Complete Care, Inc.

Medi-Health, Inc.

American Home Health Care

Visiting Nurse Association of Hillsborough County

Mid-South Home Health Agency

Alabama Department of Health

West Alabama Home Health Agency

Community Health Services, Inc.

Professional Home Health Care

Professional Home Health Care of East Tennessee, Inc.

Home Health Care

Mid-South Comprehensive Home Health Service

Maury Home Health Agency

Delta Medical Center

North Mississippi Home Health Agency

Tennessee Valley Health Service

Home Health Service of Mississippi

Central Mississippi Home Health Agency

Covington County Hospital

Community Home Health Care Association

Alexander's Home Health Agency

Whitley County Home Health Agency

Knox County Home Health Agency

Frontier Nursing Services, Home Health Agency